A Qualitative Study of Migrant Nigerian Mothers' and Midwives' Perceptions of Cultural Competency in Antenatal Care

Sarah Esegbona-Adeigbe

Submitted to the University of Hertfordshire in partial fulfilment of the requirements of the degree of PhD

September 2024

Contents

Abstract 9

Acknowledgements 10

Glossary 11

Chapter 1. Introduction and Background 12

1.1 Historical context of Black African maternal deaths in the UK 12

1.2 Migration and Black African women 14

1.3 Recent migration and maternal mortality 15

1.4 Utilisation of antenatal care and cultural factors 15

1.5 Black African women and maternal morbidity 16

1.6 Black African women and infant mortality 17

1.7 Barriers to UK healthcare for migrant Black African women 17

1.8 Cultural focus in national guidance 19

1.9 Conceptual framework 20

1.10 Influence of culture on health beliefs 23

1.11 Cultural competency 25

1.12 Cultural Competency Models 25

1.13 Cultural safety vs cultural competency 27

1.14 Cultural competency in midwifery practice 28

1.15 Eurocentric methodologies 29

1.16 Culturally sensitive research 31

1.17 Personal reflection 32

1.18 Contribution of this study to knowledge 33

1.19 Research Aims 33

1.20 Summary 34

Chapter 2. Literature Review 36

2.1 Literature review methods 36

2.2 Search strategy 37

2.3 Review of papers 39

2.4 Quality Assessment of papers 41

2.5 Synthesis 53

2.6 Literature review results 53

2.7 Studies on migrant Black women's experiences of maternity care 59

2.8 Health care providers' views of providing care for migrant Black African women 70

2.9 Grey literature 75

2.10 Identification of gaps in the evidence 76

2.11 The research question 77

2.12 Summary of chapter 78

Chapter 3: Methodology 80

Introduction 80

3.1 The research questions 80

3.2 Qualitative research 80

3.3 Ontological and epistemological view 81

3.4 Qualitative research approaches 83

3.5 Impact of Covid 19 on data collection 86

3.6 Data collection methods 87

3.7 Sampling 90

3.8 Selection criteria 92

3.9 Development of the interview schedule 93

3.10 Development of the participant information sheet and consent forms 93

3.11 Gaining ethical approval 94

3.12 Recommencing PhD study 95

3.13 Barriers and gatekeepers.....95

3.14 Research phases 97

3.15 Characteristics of midwives 98

3.16 Phase two.....100

3.17 Characteristics of mothers 100

3.18 Data analysis.....103

3.19 Reflexivity.....106

3.20 Trustworthiness.....109

3.21 Chapter summary 110

Chapter 4: Findings Phase One- Midwives 111

4.1 Structure of antenatal care provision in each Trust 111

4.2 Research findings- Focus groups.....112

4.3 Theme 1: Antenatal care in the midst of cultural ambiguity 114

4.4 Theme 2: Creating a space for sharing of cultural understanding.....120

4.5 Theme 3: Preserving culture and individuality 127

4.6 Theme 4: Cultural hesitancy and impediments to antenatal care 135

4.7 Summary of findings 138

Chapter 5: Findings Phase Two- Nigerian Mothers……..……..……140

5.1 Theme 1: Overlooking culture during pregnancy care.....143

5.2 Theme 2: Sharing but not exposing culture.....147

5.3 Theme 3: Cultural expectations of antenatal care 154

5.4 Theme 4: Navigating pregnancy within two cultures 160

5.5 Theme 5: Cultural opinions on information needs 164

5.6 Theme 6. Essence of care versus cultural knowing and skill.....169

5.7 Theme 7: Culturally embraced communication and interactions.....173

5.8 Theme 8: Respectfulness across cultures 178

5.9 Summary of findings 181

Chapter 6: Discussion 182

6.1 Themes 183

6.2 Conceptual framework 184

6.3 Cultural awareness and sensitivity 185

6.4 Cultural skill 194

6.5 Cultural knowledge.....199

6.6 Cultural encounters 207

6.7 Cultural desire.....212

6.8 Summary 214

Chapter 7: Conclusion 217

7.1 Contribution to existing knowledge 217

7.2 Importance of cultural competency in routine antenatal care 218

7.3 Midwives' recognition of culturally competent antenatal care 218

7.4 Cultural connection between migrant mothers and midwives 220

7.5 Unique contribution to knowledge.....220

7.6 Unexpected findings 223

7.7 Limitations.....224

7.8 Recommendations.....227

7.9 Dissemination 232

7.10 Autobiographical reflection 233

7.11 Research influence.....233

7.12 Conclusion 234

References 237

Appendix 1: Mind Map 330

Appendix 2: Literature search- Health databases 331

Appendix 3: Literature search- Grey literature/sociology/social care databases 332

Appendix 4: Interview schedule 334

Appendix 5: Participant information sheet mothers 342

Appendix 6: Participant information sheet midwives 346

Appendix 7: Consent form mothers 349

Appendix 8: Consent form midwives 352

Appendix 9: HRA approval 355

Appendix 10: Initial NVivo codes from transcripts 357

Appendix 11- Conferences/Seminars 358

Appendix 12: Publications 360

Appendix 13: Theme 9: Experiences in labour 362

List of tables

Table 1 1: Black maternal mortality trends 2000-2021 13

Table 2 1: SPIDER (Methley et al., 2014) 39

Table 3 1: Inclusion and exclusion criteria 39

Table 4 1: PRISMA chart 40

Table 5 1: Summary of selected papers 43

Table 6 1: Trust, ethnicity, experience and years of qualification 99

Table 7 1: Pseudonyms, trust, parity, location of interviews, language, marital and educational status 102

Table 8 1: Examples of developing a code from the raw data 105

Table 9 1: Themes derived from focus groups 112

Table 10 1: Categories discussed by each focus group 113

Table 11 1: Themes and categories from the one-to-one interviews with mothers .141

Table 12 1: Pseudonyms, parity, age of baby, mothers age and length of time in UK 142

List of figures

Figure 1 1: The culture-generic model Papadopoulos et al. (1998) 26

Figure 2 1: Cultural awareness, skill, knowledge, encounters and desire Campinha-Bacote (2002) 27

Figure 3 1: Ethnicity and years qualified of midwives across both trusts.....99

Figure 4 1: Age of mother, Figure 5 1: Parity, Figure 6 1: Age of baby, Figure 7 1: Length of time in UK.....101

Figure 8 1: Process of doing content analysis 104

Figure 9 1:Example of categories and codes under theme of sharing but not exposing culture.....105

Figure 10 1: Themes from focus groups with midwives and interviews with mothers.....183

Figure 11 1: Conceptual framework of cultural competency.....184

Figure 12 1: Cultural Competency as a core of Cultural Safety.....219

Figure 13 1: Cultural negotiation as an additional construct to cultural competency.....221

Abstract

Maternal mortality is increased in Black women, particularly migrant African women. Although there are various causes for this disparity, maternal mortality reports have consistently stated that poor utilisation of antenatal care increases a woman's risk of dying. Cultural factors have been acknowledged as influencing migrant women's access and engagement with antenatal care. However, there are limited studies that document the cultural factors that are important to migrant Black African women during antenatal care provision. The aim of this study was to explore cultural competency in routine antenatal care and how this meets the needs of migrant Nigerian women. A qualitative descriptive approach was adopted for this study which was conducted in two London NHS Trusts. One-to-one interviews were undertaken with fifteen recently migrated Nigerian women who had delivered a baby in the last year at either Trust. In addition, two focus groups were conducted, each consisting of four midwives who worked at each Trust and had experience of providing routine antenatal care. The cultural competency models of Campinha-Bacote (2002) and Papadopoulos et al. (1998) were used as the conceptual framework. The findings show that midwives are aware of the importance of cultural competency during routine antenatal care provision. Four themes emerged from the focus group's discussions: (1) antenatal care in the midst of cultural ambiguity, (2) lack of space for cultural understanding, (3) preserving culture and individuality and (4) cultural hesitancy and impediments. The one-to-one interviews with Nigerian mothers revealed a complex picture of their antenatal care experiences consisting of eight themes: (1) overlooking of culture during pregnancy care, (2) sharing but not exposing culture, (3) cultural expectations of antenatal care, (4) navigating pregnancy within two cultures, (5) cultural opinions on information needs, (6) essence of care versus cultural knowing and skill, (7) culturally embraced communication and interactions and (8) respectfulness across cultures. This study shows that women are not asked about their culture during routine antenatal care provision and that women hide or protect their culture. Mothers valued their culture however, traversing pregnancy in a new country was prioritised over their cultural needs. This study also highlights that midwives' ability to demonstrate cultural competency during antenatal care provision is impacted by societal, personal, professional, and organisational factors. This research confirms the connectedness and gaps between midwives' practice and migrant Nigerian women's experiences of cultural competency in antenatal care.

Acknowledgements

I would like to thank my PhD supervisors: Dr Laura Abbott and Professor Daksha Trivedi for their continuous support, advise and encouragement during this PhD journey. Thank you to the Nigerian mothers who shared their stories so vividly and who were keen to make things better for other mothers. I would also like to thank the midwives from the two host Trusts who gave up their time to contribute to this study. I have enormous gratitude to my family, particularly my sisters who were pillars of support and to my two children who understood this was a big project. Finally, I would like to thank my Late parents who as migrants to the UK, understood the value of education, their memory motivated me to finish what I had started.

Glossary

Antenatal care- Care provided to women or birthing people during pregnancy and up until delivery of the baby

Asylum seeker- A person who is seeking international protection from their own country and is awaiting confirmation of their refugee status

Case loading- A model of midwifery care where one midwife provides care for a group of women throughout pregnancy and childbirth and the postnatal period

Cultural awareness- An ability to recognise the differences and similarities between different cultures

Cultural desire- An individual's desire or motivation to engage in the process of becoming culturally aware

Cultural encounters- Interactions or contact with individuals from different cultures

Cultural Knowledge-The understanding of values, customs and practices that are shared by a cultural group

Cultural safety- A concept that aims to treat all people from all cultures with respect, ensuring inclusivity and protection of their cultural identity

Cultural sensitivity- An acceptance and understanding of other cultures and the ability to act appropriately

Cultural skill- An ability to perform culturally appropriate communication and assessments to retrieve relevant information

Female Genital Mutilation- A procedure where the female genitalia is cut, injured, or altered, for no medical reason

Gestation- The period of time that a baby is carried in the womb during pregnancy

Immigrant – A person who moves permanently to another country

Migrant – A person who has moved from one place to another or one country to another

Parity- Number of live births

Refugee- A person who has been forced to leave their country due to conflict or persecution and has crossed an international border for safety

Chapter 1. Introduction and Background

A Black maternal death in the United Kingdom (UK) has become a common phenomenon. Maternal mortality reports highlight that migrant Black women, particularly Nigerian women, have had up to a seven-fold risk of dying in childbirth in the UK, compared to other White ethnic groups since 2000 (Centre for Maternal and Child Health Enquiries (CMACE); 2011; Knight et al., 2023). Many women of African descent in the UK have migrated during the reproductive years of their lives. Consequently, women have had to deal with the life changing effects of immigration and childbearing, both probable causes of poor health (Behboudi-Gandevani et al., 2022). Cultural factors have been connected to Black women's poor engagement with antenatal care leading to adverse pregnancy outcomes (Knight et al., 2020; 2021; 2022), yet there is sparse research in this area. The aim of this study was to add to the body of knowledge about migrant Nigerian mothers' cultural expectations during pregnancy and midwives' understanding of cultural competency in antenatal care. This chapter provides an overview of maternal mortality rates among Black African women in the UK since 2000, considering the historical and present-day context. Additionally, it discusses maternal morbidity and infant mortality for this demographic. An overview of Black African's migration in the UK and their health needs will be presented and the importance of cultural competency and cultural safety in healthcare. The conceptual framework which underpins this study will be discussed and the justification for this research will be provided and the aims and objectives of the study set out. This chapter will conclude with a synopsis of each of the subsequent chapters.

1.1 Historical context of Black African maternal deaths in the UK

The chronology of Black maternal deaths in the UK demonstrates the persistent racial disparities in pregnancy outcomes and the inability to reduce this trend despite findings and recommendations published in eight maternal mortality reports spanning nearly two decades. Confidential enquiries into maternal deaths have identified a higher mortality rate for women of Black African ethnicity compared to White women since 2000 (CMACE, 2011; Knight et al., 2023). Prior to 2000, maternal mortality reports grouped Black African, Black Caribbean, Black Other and Black mixed women together for the Office for National Statistics (ONS) codes. However, in the Confidential Enquiries into Maternal and Child Health (CEMACH), report for 2000-2002, Black African women were audited separately as it was noted that they had the greatest risk for maternal deaths, at 72.1 per 100,000 maternities compared to a rate of 10.7 for White women showing a seven-fold increased risk (table 1 1) (CEMACH, 2004).

Table 1 1: Black maternal mortality trends 2000-2021

Year	Number of Black women who died	African countries of birth	Estimated maternal mortality rate per 100,000 maternities. African- Black/White women	Source
2000-2002	30 African women	Not provided	72.1 /10.7	CEMACH, 2004
2003-2005	35 African women	Nigeria, Somalia, Ethiopia, and Francophone countries	62.4/11.1	Lewis, 2007
2006-2008	28 African women	Only Nigeria mentioned as main country travelled from for health tourism	32.8/8.5	CMACE, 2011
2009-2012	28 African women	Mainly Nigeria, Somalia, and Ghana	26.9/9 Women born in Nigeria had the highest mortality rate, 34.2 per 1000,000 maternities,	Knight et al., 2014
2013-2015	19 African women	Mainly Nigeria, Somalia, and Democratic Republic of Congo	*31.13/7.42 *England only/includes Black African/Afro-Caribbean	Knight et al., 2017
2016-2018	18 African women	Mainly Nigeria	34.27/7.87	Knight et al., 2020
2017-2019	25 Black women	Mainly Nigeria	31.61/7.04	Knight et al., 2021
2018-2020	26 women (includes all Black women)	In particular Nigeria and Ghana	33.99/9.23	Knight et al., 2022
2019-2021	24 Black women (17 African women)	In particular Ghana, Nigeria, South Africa, and Zimbabwe	37.19/9.68	Knight et al., 2023

There was a decrease (seven-fold to four-fold), in Black African maternal deaths between 2003-2008, (CMACE, 2011; Lewis, 2007). Maternal mortality rates between 2009-2012, showed that Black African women were three times more likely to die than White women (Knight et al., 2014). Maternal mortality was increased four-fold between 2013-2015 and five-fold from 2014 to 2016 for Black women compared to White women (Knight et al., 2016; 2017; 2018). These statistics heightened public awareness that mortality rates for Black women remained essentially unchanged over the last decade. Pregnancy inequalities continued between 2016-2023, with a non-significant reduction of Black maternal deaths from the five-fold difference reported in the previous maternal mortality report to almost four times more compared to White women (Knight et al., 2020; 2022; 2023). It is noted that Nigerian women had an elevated risk for maternal mortality since the first reported increase for Black Africans in 2000 (Knight et al., 2020; 2023; Lewis, 2007), highlighting the relevance of including their experiences in dissecting the phenomenon of maternal mortality in Black African women.

1.2 Migration and Black African women

Black Africans started migrating to the UK from West Africa as students in the 1960s, from Somalia, Eritrea, and Ethiopia due to the countries' civil wars in the 1970s, and from Uganda due to civil unrest in the 1980s (Domboka, 2017). More recently, African women may have migrated to the UK due to poor socio-economic status in their countries (Osayemwenre et al., 2023). Many women of African descent in the UK have migrated during the reproductive years of their lives (Pathak et al., 2024). Complex causal pathways are caused by migration and socioeconomic factors that are linked to maternal mortality and morbidity for Black African women (Jones et al., 2022). Migrant Black African women are particularly vulnerable to poorer health in pregnancy related to poor pre conceptual care (Home Office, 2021; Ukoko, 2005), this is important due to the potential increased population of this maternity group in the UK. In 2021, the Black African group was the third largest individual ethnic group in England and Wales, with a population of approximately 1.5 million (ONS, 2021a). It is estimated that the Black African group in London will rise in number from 623 thousand in 2016 to 781 thousand in 2041, falling second to the Indian group (London Datastore, 2015). The total births to women born in countries outside the UK in 2015, was 192,227, with Nigeria (1%), listed as one of the top ten countries (ONS, 2016). In 2019, two London boroughs in the top six for births to mothers born in Africa were selected for this study as statistics and projections showed that a large population of Nigerian women resided in these areas (London Datastore, 2019).

1.3 Recent migration and maternal mortality

Recent migration to the UK and Black ethnicity has been linked to maternal deaths for more than two decades (Knight et al., 2023). Only four of the women who died in 2003-2005, were UK citizens, the remaining women (88%), were new immigrants, refugees, or asylum seekers, more than double the numbers of cases in the previous report (Lewis, 2007). The Black women who died during this period had migrated mainly from Nigeria, Somalia, and Ethiopia as well as Francophone countries (Lewis, 2007). It was suggested by Lewis (2007), that increased mortality for Black women may not only reflect the cultural and language factors implied in ethnicity but also the social circumstances of having to adapt to a new country due to recent migration. The Black African women who died between 2006-2012, were also mainly new immigrants, refugees, or asylum seekers (CMACE, 2011, Knight et al., 2014).

Recent migration continued to be a common factor in later maternal mortality reports. The Black African women who died between 2013 to 2016, had been in the UK a median of 3 to 3.5 years and were mainly from Nigeria, Somalia, and Democratic Republic of Congo (Knight et al., 2017; 2018). This trend continued from 2016 to 2018, where the women who died were mainly from Nigeria and had a median arrival time in the UK of five and a half years (Knight et al., 2020). Recent migration of five years featured as a factor in the 2023 maternal mortality report, with Nigerian born women, having a higher risk of death (Knight et al., 2023). Puthussery (2016), argues that ethnic grouping regardless of migrant status is a significant risk factor for unfavourable outcomes for migrant mothers in the UK. The link between recent migrants and maternal mortality highlighted the need for further exploration of why these inequities occur.

1.4 Utilisation of antenatal care and cultural factors

The National Institute for Health and Care Excellence (NICE), recommends that antenatal care should include booking for pregnancy at less than 10 weeks gestation and no missed antenatal appointments (NICE, 2021). Inadequate antenatal care being connected to the women who died was first revealed between 2003-2005 (Lewis, 2007). Significantly, during this period, some of the Black African women who died appeared to have been denied access to care due to cultural practices, where responsibility for decision making fell to the husband or other family members (Lewis, 2007). Failure to engage with maternity services was a common trend with the women who died between 2006-2008, with a suggestion that this may be linked to cultural factors (CMACE,

2011). However, during this period Black African women were more readily able to access antenatal care, possibly due to government recommendations that women should have direct access to maternity care. Out of the 28 Black African mortalities between 2009-2012, nine Nigerian women were reported to have died, with only one woman receiving the NICE recommended standard of antenatal care (Knight et al., 2014). The maternal deaths between 2014 to 2021 revealed that the number of women that received the NICE recommended level of antenatal care remained low (Knight et al., 2014; 2018; 2020; 2023). It was noted during this period that communication difficulties seem to have been magnified for Black African women, due to misinterpretation by healthcare workers of different cultural expressions of illness (Knight et al., 2020). The importance of being aware of cultural stigmas and culturally sensitivity care was highlighted in the 2022 maternal mortality report (Knight et al., 2022). The challenges encountered by midwives in providing care for migrant women are exacerbated by lack of understanding regarding the diverse reasons why women may not seek or attend for antenatal care. Effective engagement with migrant women requires an understanding of their dilemmas. African women are known to be at greater risk than White women of pregnancy related diseases such as preeclampsia[1] and gestational diabetes requiring more frequent monitoring during the antenatal period (Nellums et al., 2021). Ethnicity and culture have been closely linked in the research literature, two factors which influence health seeking behaviour (Arshad & Chung, 2022; Esegbona-Adeigbe, 2018; Hall et al., 2016; Lebano et al., 2020, Lokugamage et al., 2023; Manstead, 2018). However, there remains a gap in the evidence regarding the reasons for Black African women's poor utilisation of antenatal care (Knight et al. 2022).

1.5 Black African women and maternal morbidity

Maternal morbidity is increased in women of African descent in the UK (Knight et al. 2021; 2023). The odds of severe maternal morbidity are 83% higher for Black African women throughout all stages of pregnancy compared with White European women (Nair et al., 2014a). A World Health Organisation (WHO), scoping exercise found that there are 20-30 cases of maternal morbidity for every maternal death (Vanderkruik et al., 2013). There are similarities in maternal morbidity and maternal mortality for Black African women in the UK. The UK Obstetric Surveillance System (UKOSS) conducted a case study of 1753 women between February 2005 and January 2013, which found that inadequate utilisation of antenatal services doubled a woman's risk of maternal morbidity, noted to be higher

[1] Preeclampsia- A pregnancy complication that causes high blood pressure, protein in the urine and other organ dysfunction

among Black African women; other factors were lack of information, language barriers or cultural differences (Nair et al., 2014b). These findings signify that there are Black African women who may have survived pregnancy but are likely to experience ill health compared to other women.

1.6 Black African women and infant mortality

A maternal mortality may result in death of the fetus and is known to affect the educational and economic status of surviving children (CMACE, 2011; United Nations Population Fund (UNFPA), 2010; WHO, 2015). Infant mortality is increased, 48-138% higher among women of non-White ethnicity compared to White ethnic groups (Opondo et al., 2020). Infant mortality is connected to behavioural and cultural factors including acculturation, experience/perception of racism, gender inequality, maternal stress, and assumed biological differences between ethnic groups (Gray et al., 2009). A report from the House of Parliament stated that an inability to access antenatal and postnatal care leads to increased infant mortality in women from non-White ethnic groups (Rough & Baker, 2016). The added impact of a maternal death on the wider family and community strengthens the importance of investigating the circumstances that lead to a woman dying during pregnancy.

1.7 Barriers to UK healthcare for migrant Black African women

Black ethnic populations experience poorer health and barriers to accessing services in the UK (Szczepura, 2005; Garcia, 2022; Germain & Yong, 2020). Ensuring that healthcare needs of all ethnicities are met requires an understanding of the reasons why access to healthcare in the UK is an ongoing issue despite free access. Due to an increase of migrants into the UK, healthcare services were adapted to reduce disparities in health and poor health outcomes for individuals from other countries. A survey on the health of non-White ethnic groups was conducted in 1999 (Erens et al., 2001). This survey aimed to provide information on non-White ethnic group's health and monitor selected health targets showing differences in their healthcare needs compared to the population as a whole (Erens et al., 2001). One relevant omission in this report was that Black Africans were not included in the survey. A further boost study was commenced in 1999 to explore the feasibility of extending national health surveys to Black African populations living in the UK (Elam & Chinouya, 2000). Several points were apparent from the findings, African communities valued varied culture of their different tribes and clans, length of time resident in the UK impacted on knowledge and familiarity with healthcare services and African people followed different religions which impacted on health beliefs and attitudes to illness (Elam & Chinouya, 2000).The findings from this study demonstrated that there are several factors that determine the health seeking behaviours

of Black Africans. Stage two of this feasibility study was conducted in 2001 and looked specifically at the cultural and traditional practices of Black Africans living in the UK (Elam et al., 2001). These cultural practices were considered relevant due to the lack of information on Black African culture in relation to health. This stage two feasibility study highlighted the need for cultural awareness and cultural competency for health care professionals. This led to the incorporation of cultural competency training for health professionals in the NHS, with investment in study days and short courses (Papadopoulos et al., 1998).

The Race Relations Act (Amendment) (2000) also placed a duty on health and education authorities to respect the needs of individuals from all cultures. Despite these steps to increase access to health care for Black Africans, there was limited impact in this area. This was evident when the Department of Health (DoH), published a report on the self-reported experiences of patients from Black and minority ethnic groups which revealed that there were negative responses about access to health care and information and choice relating to care (DoH, 2009). More recently, health inequalities for Black populations were reported by the King's Fund, thought to be caused by a complex interplay of many factors including deprivation, environmental, health related behaviour and the 'healthy migrant effect' [2] (Raleigh, 2023). There is a scarcity of literature examining the health status of migrant women before their arrival into the UK and the potential pregnancy related complications they may face (Bains et al. 2021). In 2003, the NHS started to record ethnicity of service users however, it neglected to record socioeconomic status, nation of origin, period since migration and generation of migration (Saunders et al., 2013). Therefore, vital information was not recorded which can be argued was necessary to determine causes of health variants of migrant Black African women. The absence of this information also obscured the analysis of what health seeking behaviours may have been affected by these variables.

Black African women who are newly arrived immigrants or asylum seekers pose several issues to healthcare services, as they constitute a vulnerable group (Bains et al., 2021; WHO, 2018). A systematic review conducted by Reproductive Outcome and Migration (ROAM); collaboration showed that there were poorer prenatal outcomes for sub-Saharan African immigrant women than

[2] The healthy migrant effect is the mortality advantage in migrants relative to the majority population in the host country that is reported in many countries. It could be due to the selective migration of healthy individuals and/or healthier lifestyle such as no smoking and alcohol consumption.

other majority migrant populations (Gagnon et al., 2009). It is expected that engagement with a sophisticated healthcare system in the UK would produce pregnancy outcomes equivalent to native women (Bollini et al., 2009). However, recently migrated Black African women may lack knowledge of how the healthcare service works within the UK. Fear and anxiety may influence their health seeking behaviour whether due to unfamiliarity of the system or fear of prosecution if awaiting asylum (McKnight et al., 2019; Ndirangu & Evans 2009). These factors are underlying problems, which may influence a woman's choice to approach services for health care or advice. If access is made then other issues may arise, these range from language/communication barriers to culturally insensitive services (Hiam et al., 2019; Maclellan et al., 2022; McKnight et al., 2019). Therefore, an understanding of culture and how it is manifested in migrant Black African women is important for healthcare providers and may further illuminate the impact on their health seeking behaviour.

1.8 Cultural focus in national guidance

Over the course of the last two decades various policies have been developed to cater for the healthcare needs of marginalised women. National policies have recommended culturally sensitive services are needed to engage with pregnant women. Several policies developed by the DoH to cater for the diverse childbearing population in the UK and increase access to maternity services, included Sure Start clinics for easier access to health advice and allowing self-referral for midwifery care (DoH, 2004; DoH, 2007). Maternity Matters (DoH, 2007) stipulated that additional skills and resources might be needed to support challenged communities. However, Maternity Matters did not specify what type of resources would be adequate in meeting the needs of challenged communities. This left the arena open for individual maternity care providers to develop resources at local level. Recommended target populations included lower socio-economic class, teenagers, asylum seekers, and refugees all of which may apply to Black African women. The Royal College of Gynaecologists and Obstetricians (RCOG), maternity care guidelines attempted to cater for women with social needs, stating that services should be culturally sensitive to motivate vulnerable women to engage with maternity services (RCOG, 2008). However, women with complex social factors, including recent migrants, claimed they still did not understand the healthcare system and how it worked and reported lack of cultural sensitivity among providers (Chinouya & Madziva, 2019; NICE, 2010).

NICE guidance for women with complex social factors were developed, to set out how health care professionals could improve their pregnancy outcomes (NICE, 2010). This guidance highlighted that consideration of cultural factors in maternity care continued to be an important aspect of providing

high quality care. A National Maternity Review commissioned to improve choice and safer care for women, reported their dissatisfaction with maternity services (NHS England, 2016). The key concerns raised in this review were around the need for healthcare professionals to comprehend and respect the cultural and personal circumstances of women from diverse backgrounds aiming to enhance their childbirth experiences (NHS England, 2016). More recently, the Covid 19 pandemic highlighted the intersectional barriers for migrant women and that cultural associations with race were present, such as inequalities in accessing healthcare, and cultural barriers, such as language, and communication issues and stigma (Germain & Yong, 2020). These reports and guidance highlight the challenges faced by maternity care providers in providing care and suggests the focus in this study needs to understand the role culture plays in the healthcare experiences of migrant Black African women.

1.9 Conceptual framework

A conceptual framework is a network of interrelated concepts that merge to provide a comprehensive understanding of a phenomenon (Tamene, 2016). Qualitative studies utilise conceptual frameworks so that key factors and variables are studied and the relationship between them are explained (Miles & Huberman, 1994), whilst the theoretical perspectives provide the principal philosophies that guide the research process. In the context of this study, the conceptual framework of cultural competency resonated with the research problem of increased maternal deaths in migrant Black African women. This conceptual framework aligned with the theoretical perspectives of culture and acculturation and their impact on health seeking behaviour and African beliefs surrounding health and illness. I employed these theories of the phenomenon to refine the research aims, develop the research questions and select appropriate research methods, thereby creating a coherent perspective and understanding of this study (Maxwell, 2008). By utilising a conceptual framework, I clarified the content and justified the need of this study and explored the phenomenon through a specific lens. In the next sections, culture, acculturation, and impact on health seeking behaviour and health beliefs are first discussed followed by the conceptual framework of cultural competency.

1.9.1 Culture

A key factor in the conceptual framework of cultural competency is the concept of culture. Leininger (1997) defines culture as the shared values, beliefs and customs of a specific group or population that guides their decisions and actions. Culture is also viewed as a set of guidelines that individuals inherit as members of a particular group, which influences how the world is viewed emotionally and

behaviour in relation to other people and the natural environment (Helman, 2007). Therefore, the significance of culture on the behaviour of migrant Black African women is important in this study. It is declared that culture encompasses age or generation; gender; sexual orientation, occupation, and socioeconomic status; ethnic origin or migrant experience and religious or spiritual beliefs (Holland, 2017; Nursing Council of New Zealand, 2011). This demonstrates that culture is not just related to ethnicity but to external factors which may influence an individual's viewpoint and beliefs. Individuals do not need to be located in a particular place for culture to be maintained as tradition passes down from generation-to-generation, customs, beliefs, and practices of long standing (Esegbona-Adeigbe, 2011), therefore culture is sustained provided there is an individual to continue these practices. It is the individual that maintains cultural practices not the environment. Culture has three levels, a tertiary level that is visible to the outsider such as traditional dress and foods, a secondary level of underlying rules and guidelines not generally relayed to outsiders, including taboos and rituals relating to behaviour (Hall, 1984). The primary level of culture are rules that are known and obeyed by all and may be almost unconsciously performed and is more stable and the most resistant to change (Hall, 1984). Examples of the primary level of culture are inherent respect for elders, family and community and culturally acceptable methods of communication. The primary level of culture presents a challenge in the provision of health services as healthcare professionals' unawareness of some cultural practices may create unseen barriers. Hence, it is important for healthcare providers to be aware that an individual may have cultural values and norms which they wish to adhere to, when accessing and engaging with healthcare services. Despite the limited literature on migrant Black African women's health in the UK, it is agreed that cultural factors play some role in their health seeking behaviour (Knight et al., 2018, 2019).

1.9.2 Acculturation

As recent migration is a key factor linked to antenatal care utilisation by migrant Black African women in this study, an understanding of acculturation is required. Acculturation refers to the process of cultural and psychological change that occurs when two cultures meet (Sam & Berry, 2010), there may be an amalgamation of a person's culture with the new culture or a dominance of one culture over another. One cannot assume that acculturation occurs for every individual and if so to what extent. Behavioural factors due to the process of cultural change or 'acculturation' which involve the adoption of customs, norms and practices of the host country may act as potential contributors to differences in perinatal outcomes between first and subsequent generations of migrants (Puthussery, 2016). There are two factors that influence acculturation, the desire of individuals to

preserve their heritage, cultures and identities, and their willingness to engage with the dominant culture and actively participate in the broader society's daily life (Sam & Berry, 2010). Contact with people outside of their culture may not necessarily mean that a person adapts to another culture as there may still be adherence to their own usual cultural practices.

Berry (2006) discusses four acculturation strategies; the first type is integration; this is when the individual maintains his or her own cultural identity and at the same time participates in the host culture. Individuals who integrate seek to be a member of the larger social network (Sam & Berry, 2010). Midwives may frequently encounter women who appear to have integrated, due to change in their attire, their employment/ job role, and their ability to navigate maternity services, all factors that demonstrate that the woman may be adapting well to living in another country. Integration also requires identification with the host culture while maintaining identification with the home culture, also known as biculturalism (La Fromboise et al., 1993). There are many factors that causes a woman to integrate, one being that it is easier due to the need to engage in employment and education in the new country. If there are any language barriers, this will impact on integration due to the restrictions in communicating with the dominant culture. Accessing healthcare services and seeking health advice may be less challenging for individuals who have integrated. Culture shock can occur with some individuals where there is personal disorientation when dealing with an unfamiliar way of life (Cupsa, 2018). Integration reduces the negative effects of culture shock and can also lead to better psychological outcomes such as lower rates of depression (Virta et al., 2004). Women may feel less isolated if they integrate especially if they are not living with family or close to communities who share the same culture as themselves. Women who integrate can acquire support from the new cultural groups but still seek support from their own cultural groups.

Assimilation occurs when a person disregards their own cultural identity and becomes absorbed into the host culture (Sam & Berry, 2010). This is more likely to happen with younger individuals, often due to contact with other cultures through educational endeavours. In assimilation, individuals adopt the practices and outlook of the dominant culture and abstain from their culture of origin, often by seeking regular contact with the dominant society and avoiding maintenance of their original identity (Fox et al., 2013). This may lead to disconnection from family or friends. Women who assimilate may lose lack of support networks; however, it is possible that such support may be available in the host culture. Berry (2006) also discusses separation, a type of acculturation where the individual maintains his or her own cultural identity and rejects involvement with the host culture. Individuals

who fall into the separation category are essentially the opposite of those who assimilate; they reject or avoid the new, dominant culture in favour of preserving their ethnic identity, often by highly valuing their original cultural practices and avoiding contact with dominant society individuals (Fox et al., 2013). Women who have language barriers or little social contact outside of their family and community are most likely to fall into this category. Women may voluntarily separate from the dominant culture due to fear of living in a new country and meeting different people, also due to a personal value of adhering to cultural, spiritual, or religious beliefs. Women may be enforced to separate from the dominant culture due to issues such as domestic violence or slavery. The psychological health of individuals who adopt the separation strategy is said to be worse than individuals who integrate or assimilate (Berry, 2006). However, it is acknowledged that if separation is voluntary this can lead to less stress. Midwives may encounter women who appear to be separated, and it may be necessary to explore why this may have occurred to ensure that access or utilisation of healthcare is not impacted.

Marginalisation is where individuals do not identify or partake in either their own culture or the host culture (Berry, 2006). This occurs due to little possibility of or lack of interest in cultural maintenance, failed attempts to acculturate or little interest in having relations with others due to exclusion or discrimination (Sam & Berry, 2010; Sheikh & Andersen, 2018). Marginalisation is often associated with negative outcomes which may impact on pregnancy, such as causing depression and lower self-esteem (Berry & Sabatier, 2010; Sawrikar & Hunt, 2005; Virta et al., 2004). Studies have shown that marginalisation may apply to a small sample of migrants, and it is even suggested that this group is non-existent (Schwartz & Zamboanga, 2008; Unger et al., 2002). Marginalisation is queried as an impractical concept and that even in cases of discrimination, individuals are more likely to reframe their culture of origin rather than be left cultureless (Del Pilar & Udasco, 2004). The connection of recent migration to Black African maternal deaths is illuminated by the multidimensional impact of acculturation.

1.10 Influence of culture on health beliefs

Cultural influences on health beliefs is an important factor in the conceptual framework for this study. Maternal mortality reports have frequently alluded to cultural influences on antenatal care attendance for migrant Black African women (Knight et al., 2018; 2019; 2023). Migrant Black African women particularly refugees or newly arrived immigrants may face challenges during pregnancy due to

Western influences which may challenge their cultural beliefs (Esegbona-Adeigbe, 2018). Cultural health beliefs which conflict with Western health beliefs of pregnancy care, are purported to make it difficult for African women to engage with health services (Ojua et al., 2013). Practices surrounding pregnancy are particularly revered, as healthy offspring ensure the survival of family lines. Therefore, there may be cultural practices adopted by migrant Black African women that are harmful as they prevent individuals from seeking health advice or they may be non-detrimental (Esegbona-Adeigbe, 2011). Midwives should explore harmful practices with women to gain some negotiation and compromise during pregnancy (Dike, 2019). The lack of knowledge of these practices may pose difficulties for midwives when attempting to provide advice that does not conflict with the woman's cultural beliefs (Esegbona-Adeigbe, 2022).

Cultural needs are likely to be more persistent than language needs in immigrant groups according to (Szczepura, 2005), these might include healing and wellness belief systems and how illness, disease and their causes are perceived. Knowledge of cultural health beliefs may be useful when trying to engage with cultural groups, as these factors can influence a person's health seeking behaviour and acceptance of health advice and treatment. In the context of this study, understanding of how Black African women perceive health and wellbeing during pregnancy is important. African traditional healing practices rely on beliefs that have existed long before the spread of modern medicine; these practices vary in different African countries (Kubukeli, 1999). It is acknowledged that African populations rely on traditional medicines and believe in spiritual treatments and divination (Awuchi, 2023; Mattelaer, 2005; Ojua et al., 2013; Shewamene et al., 2017). These beliefs may be maintained by migrant Black African women during pregnancy in the diaspora[3] and what occurs is a mix of Western and African practices, which persist despite acculturation. Optimum health for Africans constitutes mental, physical, spiritual, and emotional stability for oneself and their families (Aderibigbe, 2015; Omonzejele 2008). Therefore, there is an interplay of societal, familial, and personal factors that maintain the continuance of culturally related healthcare practices.

[3] Diaspora- Populations of people who come from a particular country and are living in other parts of the world

1.11 Cultural competency

The suggested link between culture and reduced utilisation of antenatal care for migrant Black African women supports the exploration of the concepts of cultural competency in healthcare provision. The term cultural competency, first devised by Cross (1989), is a set of congruent behaviours, attitudes and policies that come together in a system, supporting professionals to work effectively in cross-cultural situations. Consideration of cultural factors in the provision of healthcare are needed to work effectively with diverse populations. Cultural competency is a recognised standard for caring for individuals from diverse backgrounds (Cross, 1989; Deliz et al., 2020; McLemore et al., 2018). Cultural competency consists of two interrelated concepts, and the definition varies depending on which part is the focus. If competency is the focus, the domains are presented as knowledge or skills, whereas if the focus is culture, then cultural values, religion, and health beliefs are more specific (Shen, 2015). A simpler definition provided by O'Hagan (2001), is that cultural competency is the ability to maximise sensitivity and minimise insensitivity in healthcare provision. Papadopoulos (2006) states that cultural competency is the capacity to provide effective healthcare which relies on considering people's cultural beliefs, behaviours, and needs. These views of cultural competency emphasise the importance of integrating an individual's cultural perspective into healthcare provision. Furthermore, the provision of culturally competent care is a multifaceted concept that incorporates not just factual knowledge of the customs, language, and social norms of another culture, but some reflection, self-awareness, and cultural humility on the part of the healthcare provider (Tobin et al., 2014).

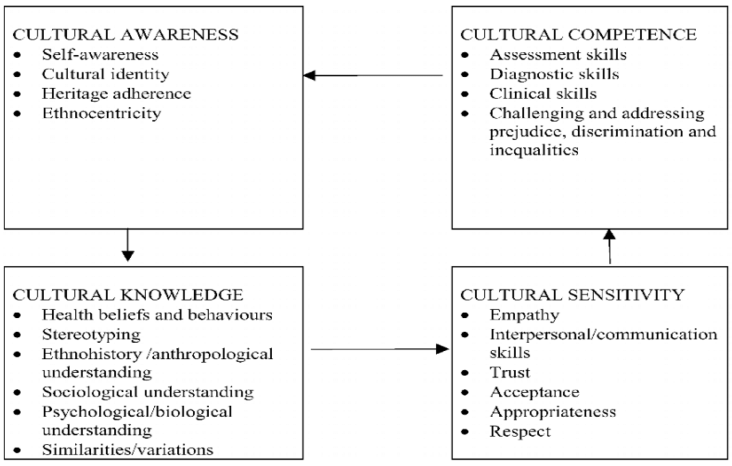
1.12 Cultural Competency Models

Two conceptual frameworks, Campinha-Bacote's (2002) and Papadopoulos et al. (1998) cultural competency models, have been selected for this study because their structures provide clear guidance for clinical practice. The focus of competency is dominant in these theoretical models, highlighting the domains of awareness, sensitivity, skills, knowledge, encounters, and desire (see glossary). Papadopoulos et al's and Campinha-Bacote's cultural competency models are both validated and are used in international nursing educational programmes and guidelines for maternity units to provide culturally appropriate care (Yadollahi et al., 2020; Papadopoulos, 2006). In a review of four cultural competency models, Albougami et al. (2016), found the Campinha-Bacote model to be appropriate to guide empirical research and the development of educational programmes. Papadopoulos et al's model urges the mandate for compulsory training for healthcare professionals with support from regulatory and healthcare institutions (Higginbottom et al., 2011). Currently, no

cultural competency models are recommended by the Nursing and Midwifery Council (NMC), although the importance of cultural competency in midwifery practice is highlighted in the standards of proficiency for midwives (NMC, 2019).

The theoretical model for developing cultural competency created by Papadopoulos et al. (1998), consists of three factors, cultural awareness, cultural knowledge, and cultural sensitivity (see figure 1 1). This model highlights the different components required to achieve cultural competency, requiring some level of self-awareness. A conceptual map is provided for each stage as a guideline. The first stage is cultural awareness which begins with an examination of personal values and beliefs and the importance of cultural identity as well as realising influences on people's value bases and beliefs (Papadopoulos et al. 1998). The second stage is cultural knowledge of the anthropological (human behaviour), sociological (social behaviour) and biological nature of culture. The third stage is cultural sensitivity, incorporating interpersonal skills (see figure 1 1). Papadopoulos et al. (1998) states that cultural sensitivity can be achieved by involving women as equal partners in their care which leads to trust, acceptance, and respect. Cultural competency is suggested to require synthesis and application of previously gained awareness and sensitivity.

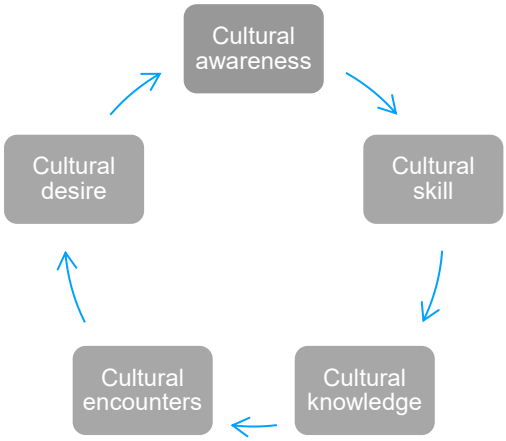
Figure 1 1: The culture- generic model (Papadopoulos et al. 1998)



The Campinha-Bacote model of cultural competency requires midwives to see themselves as becoming culturally competent rather than already being culturally competent and involves the

integration of cultural awareness, cultural skill, cultural knowledge, cultural encounters, and cultural desire (see glossary) (see figure 2 1) (Campinha-Bacote, 2002). This theoretical model reflects more than one contrasting worldview (Higginbottom et al., 2011), and the interdependent relations between the elements. Campinha-Bacote (2002) proposes that the model begins and ends with cultural encounters, and it is through these encounters that one acquires cultural knowledge, cultural awareness, cultural skill, and culture desire. Therefore, in this case cultural competency is achieved by a continuous cycle of cultural encounters. However, this model does not include the construct of cultural sensitivity which I argue is a crucial skill when providing healthcare. Therefore, the constructs of cultural competency in Papadopoulos' and Campinha-Bacote's models were both utilised to provide a comprehensive approach to culturally competent care.

Figure 2 1: Cultural awareness, skill, knowledge, encounters and desire (Campinha-Bacote, 2002)



1.13 Cultural safety vs cultural competency

It is important to acknowledge the concept of cultural safety which is advocated to be more achievable for healthcare professionals than cultural competency (Curtis et al., 2019). The relevance of cultural safety to this study was strengthened by the different theoretical perspectives which enabled further understanding of the phenomenon and to see other viewpoints. Cultural safety is the analysis of an individual's cultural self and the impact this has on encounters with service users (Curtis et al., 2019; Phiri et al., 2010; Ramsden, 2002; Yeung, 2016). In contrast to cultural competency, recognition and understanding of one's own culture, along with self-awareness, is stated to hold greater significance than solely focusing on awareness of the woman's culture (Parisa

et al., 2016). This is due to the pivotal role that one's culture plays in power dynamics within healthcare interactions (Curtis et al., 2019). It is argued that if healthcare professionals understand the bicultural nature of the patient-practitioner relationship, beginning with themselves, their own race, culture, and imprinted stereotypes, then quality of care is improved (Yeung, 2016). Therefore, cultural knowledge is not an essential factor in cultural safety differing to the concept of cultural competency. To further explain cultural safety, unsafe cultural practice comprises any action which diminishes, demeans, or disempowers the cultural identity and well-being of an individual or does not recognise the cultural identities of individuals (Esegbona-Adeigbe, 2011; Holland, 2017). Cultural safety acknowledges the barriers to clinical effectiveness which arise from the inherent power imbalances between healthcare professionals and patients (Laverty et al., 2017). The service user is the best judge of whether the professional relationship feels culturally safe (De & Richardson, 2008). This demonstrates less emphasis on the healthcare professional and more emphasis on the migrant woman to determine if care is effective, which is an aspect sought in this study.

Deciphering how cultural safety is delivered or experienced poses several issues around data collection and analysis due to the complexity of this concept (Brumpton et al., 2023; Ellis et al., 2023). Furthermore, there are limited tools available to assess cultural safety, leading to lack of conceptual clarity (Dawson et al., 2022; Kerrigan et al., 2024; Magee et al., 2024). Nevertheless, as the element of culture has been alluded to in relation to maternal mortality in migrant Black African women, incorporating the concept of cultural safety in this study would have been appropriate. However, by utilising the concept of cultural competency in this study, I was able to delve deeper into the theoretical perspectives and attain a more comprehensive understanding of the constructs, this facilitated consistency and focus in the research process.

1.14 Cultural competency in midwifery practice

Midwives are the main providers of antenatal care in the UK; therefore, they play a vital role in the quality of antenatal care provision (NICE, 2021). Therefore, factors that contributed to poor engagement of antenatal services for any woman was revealed by investigating midwives' views. This was relevant as there is a lack of rigorous research on specific maternity interventions which are aimed to provide culturally competent maternity services (Coast et al., 2014; Garcia et al., 2015; Jones et al., 2017). Furthermore, there has been various opinions that lack of cultural competency has impacted on midwives practice (Hogan et al. 2018; Fleming et al., 2019a; 2019b). It has also

been argued that improving midwives′ cultural competence would better equip them to respond to the needs of an ethnically diverse population (Aquino et al., 2015). This is strengthened by reports from healthcare professionals who felt they were unable to develop their own cultural knowledge and skills or help migrant pregnant women to develop the competencies they needed to negotiate maternity care (Phillimore, 2016).

The NMC standards of proficiency for midwives states the importance of combining clinical knowledge, understanding, and skills with interpersonal and cultural competence (NMC, 2019). I view this as a recognition that cultural competency is acknowledged as a key midwifery skill. The NMC standards do not present a unique requisite for midwives, as cultural competency is alluded to in past national policies and guidance. The NHS plan and the National Service Framework (DoH, 2000; DoH, 2004), have included an emphasis on cultural needs of women in maternity care. In the DoH report Midwifery 2020, the importance of integrating cultural competency in midwifery training was asserted as a critical component of midwives' skills (DoH, 2010). A recent review of the NMC, found at every level of the organisation, racism and discrimination and a toxic culture (Afzal & Rise Associates, 2024). Recommendations from this report included tackling racism and discrimination in midwifery practice. Therefore, this study benefited from exploring midwives' views of cultural competency, so that an etic view was acquired that added further evidence to address the issue of migrant Black African maternal mortality.

1.15 Eurocentric methodologies

In the search to determine the best approach for this PhD study, I became aware of views that challenged research methodologies that did not cater for Indigenous or non-Western cultures. It is contended that Western universities produce knowledge that is embedded in Eurocentric epistemologies which are objective and disembodied (Cupples & Grosfoguel, 2019). Therefore, non-Eurocentric, Black and Indigenous knowledge is disregarded. I felt constricted by attempting to select a research methodology that was accepted by my university, as to do otherwise would mean my research proposal was not appropriate. I realised that trying to fit my topic to a certain approach may mean I was utilising a methodology that I did not feel would justify my study. I questioned the use of a methodological approach that was grounded in Eurocentric perspectives, I wanted to value other perspectives. Black researchers who study their own communities are expected to use Western ideas and tools even when exploring culturally specific issues (Nakagawa, 2017). My position as a

Black researcher meant that I would be conducting this research from a Black perspective, but despite this had to conform to Western standards. Therefore, I was negotiating my Blackness within a Western scientific worldview, which is reported to be a complex process undertaken by non-Western researchers (Solot & Arluke, 1997). It is suggested that academia in the UK is diminished by lack of representation of Black academics who can contribute knowledge and expertise that offers diverse views (Warrener & Douglas, 2023). I found this was the case when exploring non-Eurocentric research theories, noting the dearth of information in the literature.

Decolonising research methodology is an approach that challenges Eurocentric research methods (Chilisa, 2019; Khupe & Keane, 2017). Acknowledgment of different sources of knowledge supports decolonising activity. I support the view that respect for diversity and Indigenous knowledge should be reflected in all higher education institutes, as this advances the principles of non-discriminatory behaviours and equality (Bartoli et al., 2015). The issues of power, trust, culture and cultural competency and respectful research practices are important in the decolonising process (Keikelame & Swartz, 2019). It is the process of research that fosters decolonisation, not necessarily the methodology used. I concurred with Keikelame and Swartz (2019), that ensuring the researched have their cultural or Indigenous beliefs and values protected in the research process is as equally important as hearing their views and perspectives, therefore research through a cultural lens is recommended.

I reviewed alternative data collection methods drawn from the traditions and knowledge of Indigenous people or non-Western cultures (Evans et al. 2008). Alternative methods ranged from ceremonies, art, dance, music, and storytelling, which have similarities to data collection methods used in Western methodologies. In a Western context, narrative enquiry utilises storytelling to describe everyday events, however in Indigenous populations narrations are sacred stories uniting past and present experiences which would have been appropriate for the present study (Eigenbrod & Hulan, 2008). Pictorial data collection methods such as photo elicitation, auto photography and visual ethnography are other approaches used in Western methodologies (Glaw et al., 2017). Alternatives methods such as drawings and art which denote cultural practices could have enabled my ability as a researcher to see the world through the participants' eyes, without the requirements for verbal interactions. Therefore, participants who were not fluent in the required language could convey their thoughts and feelings coherently. Dance and music have long been used as a form of non-verbal communication and similar to visual methods could have been used by participants to

express their feelings or views. In particular, song and dance could have revealed participants' cultural and traditional beliefs and practices (Dai, 2020; Smith, 2018). Pregnancy and childbirth are celebrated through rituals such as birth songs and dancing in African societies (Ohara & Anyim, 2021). These rituals would have allowed the expression and personification of the participants' viewpoint. Acceptance of alternative ways of data collection methods would have been beneficial in the present study, due to the diversity of the participants.

1.16 Culturally sensitive research

Culturally sensitive research is defined as an approach that has been modified to embrace knowledge of a cultural group such as their beliefs and values (Banister et al., 2014). The importance of cultural sensitivity in research should not be underestimated as culture impacts on human behaviour and therefore, a person's willingness to participate in research studies (Awad et al., 2016, Woodland et al., 2021). Adopting culturally sensitive methodologies did not justify my abandonment of Western research approaches, but it was useful in making adjustments so that barriers were overcome between researcher, participants, and the communities where the research took place (Datta, 2018; Igbineweka et al., 2021; Rangel & Valdez, 2017). Awareness of how culture influences behaviour equips researchers with the skill to develop interventions that fit with specific groups. I found it useful to consider the impact of past research on Black communities. Historically, research on Black communities has led to mistrust and fear (Henderson et al., 2024). Enslaved Black women were operated on without consent or anaesthesia in America during the 1840s, to perfect gynaecological procedures, resulting in the creation of the Sims speculum which is used in current healthcare practice (Campbell, 2021). Exploitation of Black women continued into the mid twentieth century, when in the 1950s, cervical cancer cells were taken from Henrietta Lack without her consent for research. These eponymous HeLa cells formed the basis for biomedical science used in cancer and invitro fertilisation and more recently during Covid vaccination trials (Beskow, 2016). The story of these HeLa cells raised ethical concerns around informed consent, privacy, and communication with donors. Further events occurred in the 1960s, when Black women had their reproductive rights controlled during research studies, by the testing of the then new contraceptive injection Depo Provera in America and Africa, without full consent leading to mass sterilisation (Campbell, 2021).

I was aware of the mistrust and fear that continued during the recent Covid 19 pandemic evidenced by the lack of participation of Black communities during the vaccination trials (Burden et al., 2021; Opel et al., 2021). As a Black researcher, I considered how my research approach had to mitigate

these concerns. Culturally sensitive research is required to counteract such issues and with the increasing diversity in the UK, there is an ethical mandate to respect the culture and values of diverse communities (Burnette et al., 2014; NHS England, 2023). My study design considered any obstacles to Black women such as fear of stigma, misinterpretations, and misconceptions. Consideration of Black women's circumstances and any participant issues was addressed when designing this study. Any obstacles were overcome by ensuring the research question was clear and easily understood and the study design catered for the relevant group.

1.17 Personal reflection

Drawing upon my background as a Black African midwife and a mother, with over twenty-five years of experience in caring for Black African women, I recognised the importance of cultural competency in midwifery practice. As a second-generation Black African, I was born in the UK but completed my secondary education in Nigeria. I was aware of some aspects of African culture. Throughout my career, listening to the perspectives and preferences of Black African women has emphasised the importance of protecting their cultural identities. During my UK nurse training, I developed an interest in Black African health, and I naturally veered towards any issues that were prevalent in African populations. I had seen poor health outcomes growing up in Africa and it was a common occurrence that people died due to limited access to healthcare. My interest in Black African health increased during my midwifery training in the 1990s. It was during this period that I became aware of the many issues facing Black African women during pregnancy, and that they were high risk for a majority of pregnancy complications such as gestational diabetes and preeclampsia. However, at this time I was not fully aware of the high prevalence of maternal mortality and morbidity for Black African women. As a community midwife I became interested in cultural practices of Black African women during pregnancy. I was invited to conduct presentations to student midwives and midwifery colleagues about African culture during pregnancy by my manager and from this point I developed a passion.

My Master's thesis was an innovation project to create a cultural knowledge resource for midwives on Black African women. I wanted to focus on an issue related to African women during pregnancy but was unsure of what the focus would be. It was at this time that the increased mortality of Black African women was highlighted during a literature review for my Master's thesis. There were several theories put forward in maternal mortality reports, as to why Black African women were dying and why this was mainly migrant women. No specific factors were related to the issues however, recent

migration, cultural factors, and connection to inadequate utilisation of antenatal care was alluded to several times in maternal mortality reports. This resonated with me as a second-generation Black African born to a first-generation Black African woman who had arrived into the UK in the 1960s and could have possibly been another maternal mortality statistic. Since, the completion of my Master's studies in 2010, the incidence of Black African women dying during pregnancy, although decreased in number is still significantly high compared to White women. Therefore, my passion and my heightened awareness of the risks Black African mothers face during pregnancy was the vehicle that led me to further my knowledge through doctoral studies.

1.18 Contribution of this study to knowledge

This study contributes to the existing body of knowledge by providing valuable insights and understanding in the following areas. Despite maternal mortality reports stating for two decades the connection of culture, inadequate utilisation of antenatal care and increased deaths in migrant Black African women, there is a dearth of knowledge on this specific triad. This study explored this triad by focusing on migrant Nigerian mothers' perceptions of cultural competency in antenatal care. To further extend this knowledge and provide an etic (outsider) view of this phenomenon, midwives' perceptions of what constitutes cultural competency in antenatal care provision were also explored. This study's findings have the potential to inform maternity care providers of strategies for addressing the cultural needs of all non-White ethnic women and how viable cultural competency training can be incorporated into midwifery education.

1.19 Research Aims

1. To explore the perceptions of migrant Nigerian women and midwives of cultural competency in antenatal care.
2. To investigate how migrant Nigerian women's perceptions of cultural competency impact on their engagement with antenatal care.
3. To explore the extent to which antenatal service provision addresses the cultural needs of Nigerian women.

1.20 Summary

Chapter one: Introduction and background

This chapter has provided a background to maternal mortality and morbidity for Black African women in the UK and introduced the concept of cultural competency. The rationale for studying Nigerian mothers' and midwives' perceptions of cultural competency in antenatal care has been explained. The theoretical perspectives and conceptual framework around which this study was built has been presented, followed by a personal reflection of Black African women and maternal mortality. A justification for this study has been offered and the aims set out with key terms defined in relation to their use within this thesis. This chapter concludes with a brief overview of each of the subsequent chapters.

Chapter two: Literature review

In this chapter the literature review approach is discussed including the literature searching technique, screening for relevant articles, extracting key data from relevant papers and a critique of the literature is presented. This begins with a critical discussion of studies from 2000 onwards and extends to consider the literature relevant to the theoretical perspectives and conceptual framework of cultural competency. The themes from the literature review are discussed and key recommendations provide a representation of the existing evidence on migrant Black African women's maternity experiences.

Chapter three: Methodology

This chapter presents the rationale for the chosen methodological approach to this study, demonstrating how this was chosen in relation to the research aims and questions. Ethical challenges of conducting research whilst holding multiple roles are discussed. The process of data analysis is described, with specific reference to the maintenance of academic rigour.

Chapters four and five: Findings

These chapters provide details on the findings of this research from the two focus groups with midwives (phase one) and the fifteen one-to-one interviews with Nigerian mothers (phase two). The categories and themes that were derived from the data are presented with a discussion of the experiences of the mothers and midwives that pertain to their views of cultural competency. The

individual stories of the mothers supported by anonymised quotations will assist in illuminating their pregnancy journeys as migrant mothers in the UK. The reality of antenatal care provision for migrant women are revealed in these chapters by discussing the experiences of midwives.

Chapter six: Discussion

This chapter critically discusses the key themes which emerged from the findings of this study in relation to the conceptual framework of cultural competency. The implications for midwives' involvement in routine antenatal care are presented. The one-to-one interviews with Nigerian mothers are also examined and suggestions for improvement at interpersonal, institutional, and national level are made.

Chapter seven: Conclusion

This concluding chapter demonstrates how the research questions have been met and how the findings contribute to the current body of knowledge. Limitations of the study are explained, followed by implications for further research and practice with migrant Black African women.

Chapter 2. Literature Review

Introduction

This chapter provides a critical review of the literature pertinent to this study. The purpose of a literature review is to analyse the current literature and provide a rationale for the research topic. The aim of this study was to explore migrant Nigerian mothers' and midwives' perceptions of cultural competency in antenatal care. UK Maternal mortality reports have confirmed the almost fourfold increased risk of maternal deaths for Black women compared to White women (Knight et al., 2023). Inadequate utilisation of routine antenatal care with cultural factors being a possible cause has been connected to poorer pregnancy outcomes for Black African women, particularly migrants. However, maternal mortality reports are brief in their regard of these cultural factors, requiring a deeper understanding of antenatal care utilisation by migrant Black African women. Whilst the evidence on the link between routine antenatal care and optimum pregnancy outcomes for Black African women is available (Knight et al., 2023; NICE, 2021), the evidence on cultural competency in antenatal care is limited. This literature review focuses on cultural competency in antenatal care for migrant Black African women. A literature review was undertaken to ensure that studies were captured that could inform the purpose of this study, as it was recognised that there are many facets to cultural competency as discussed in chapter one. This included a review of the grey literature, and primary and secondary studies. Moreover, it is possible that some studies did not explicitly aim to investigate cultural competency, yet their findings may have addressed cultural aspects. In addition, their recommendations may have underscored the significance of incorporating cultural competency in antenatal care provision. This chapter explores the available evidence on migrant Black African women's perceptions of utilising antenatal care. In addition, midwives' experiences of providing antenatal care for migrant Black women are also included. This review concludes with the gaps in the evidence that are relevant to this study. What follows is a description of the literature review methods, search strategy, and critical review of the papers retrieved and relevant findings and recommendations.

2.1 Literature review methods

Systematic reviews are considered to be the gold standard for evidence synthesis (Byrne, 2016). A literature review was conducted using a systematic approach which is a method that summarises

and evaluates all the evidence on a particular topic and can include both published and unpublished studies (Grant & Booth, 2009). Systematic reviews often focus on a narrow question in a specific context, with a previously determined method to synthesise findings (Sukhera, 2022). Bias is reduced in systematic reviews by utilising an effective research strategy (Ferrari, 2015), and quality is addressed by ensuring replicability and credibility (Pati & Lorusso, 2018). A broad exploration of the literature was required to identify any gaps in existing research on cultural competency in antenatal care which was relevant to the focus of this study. Therefore, a comprehensive systematic review was undertaken with predefined eligibility criteria to increase confidence in the review findings and conclusions and to reduce selection bias (O'Connor & Sargeant, 2015). Thematic analysis is commonly used for synthesis of primary studies and provides transparency, as codes can be looked for and themes identified (Thomas & Harden, 2008). Themes can capture the patterns in the data across a multitude of studies providing a comprehensive picture of the phenomenon being investigated. Thematic analysis was conducted for this literature review by assessing the data from included studies and extrapolating common themes, which provided a deeper understanding of the phenomenon.

2.2 Search strategy

Aveyard (2023) proposes that searches of databases should be robust, using an approach that balances sensitivity (locating all sources) and specific (locating relevant studies). Selection bias can be reduced by applying a strict inclusion and exclusion criteria, thereby improving sensitivity and specificity (McDonagh et al., 2013). Hence, I used a combination of sensitive and specific systematic searches. Soft searches were performed on Google and Google scholar to assist in the identification of appropriate and relevant search terms. Index terms differ in databases and Medical Subject Headings (MeSH) are assigned based on the paper's content. MeSH terms facilitate the location of papers that are specifically about a subject rather than the topic just being briefly mentioned (Baumann, 2016). Therefore, there is increased specificity when searching for papers. It is advised to use keywords to broaden the search and index/subject terms to focus the search appropriately. All words in the research question were not used in the search strategy, as this may have restricted the results, the recommendation is to minimise the number of elements (Bramer et al., 2018). The elements were ordered by their specificity and importance to determine the best search approach (Bramer et al., 2018). An online thesaurus was used to check for synonyms to improve the sensitivity of the search terms and broaden the words which were used to search the titles and abstract fields in the papers.

A literature review was conducted initially in February 2017 and repeated in 2018 and 2021. Alerts were created for all databases that provided this service to ensure I kept abreast with new papers. In January 2024, a further update of the literature review was conducted on the Cumulative Index to Nursing and Allied Health Literature (CINAHL) plus, MEDLINE, PUBMED, COCHRANE, INTERMID, INTERNURSE, Mark Allen Healthcare (MAH), SCOPUS, PSYCHinfo, JSTOR databases and on the Social Care online website and Google scholar. SPIDER (Sample, Phenomenon of Interest, Design, Evaluation, Research type) was used as it provides the greatest specificity for a broad range of databases (Methley et al., 2014) (see table 2 1).The search terms used which were a combination of free text and MESH, were ‘Black African,’ ‘ women,’ ‘ pregnant,’ ‘ maternal health services,’ and ‘culture and competent,’ a mind map was used to identify similar terms to capture all relevant papers (see appendix 1). Boolean operators AND and OR were used to capture any variations in phrases used in papers and the search approach was adapted for each database (see appendix 2). A broad review of the grey literature was also conducted on the British library database, Open Access theses and dissertations and Google (see appendix 3). In addition, the references of individual papers were examined to capture any other relevant studies.

I utilised other techniques to acquire obscure studies, for example, I explored ResearchGate a European commercial social networking site for researchers to share papers. This site was also useful for downloading full print copies of papers which would have required a fee to retrieve on other platforms. I also reviewed LinkedIn, a professional network on the internet where researchers shared their latest projects. The NHS Black Minority Ethnic (BME) network membership provided me with monthly updates on recent findings pertinent to Black and minority ethnic communities and the NHS. I subscribed to the Fivexmore newsletter an organisation that is committed to highlighting and transforming Black maternal outcomes in the UK (Fivexmore, 2024). This organisation conducted a national study of Black women's experiences of maternity services in the UK (Peter & Wheeler, 2022). I reviewed the King’s Fund website, a health and social care charity that provides insight and analysis of healthcare in England. I also collaborated with academics within my organisation and other doctoral students to ensure that I kept abreast with any studies that were relevant to my topic. Any papers retrieved from the searches were downloaded and stored electronically using Refworks which allowed for the creation of folders for each database.

Table 2 1: SPIDER (Methley et al., 2014)

Sample	Migrant Black African women
Phenomenon of interest	Cultural competency in antenatal care
Design	Interviews, focus groups, questionnaires, case studies, observations
Evaluation	Perceptions/Experiences
Research type	Qualitative, systematic, or narrative reviews

2.3 Review of papers

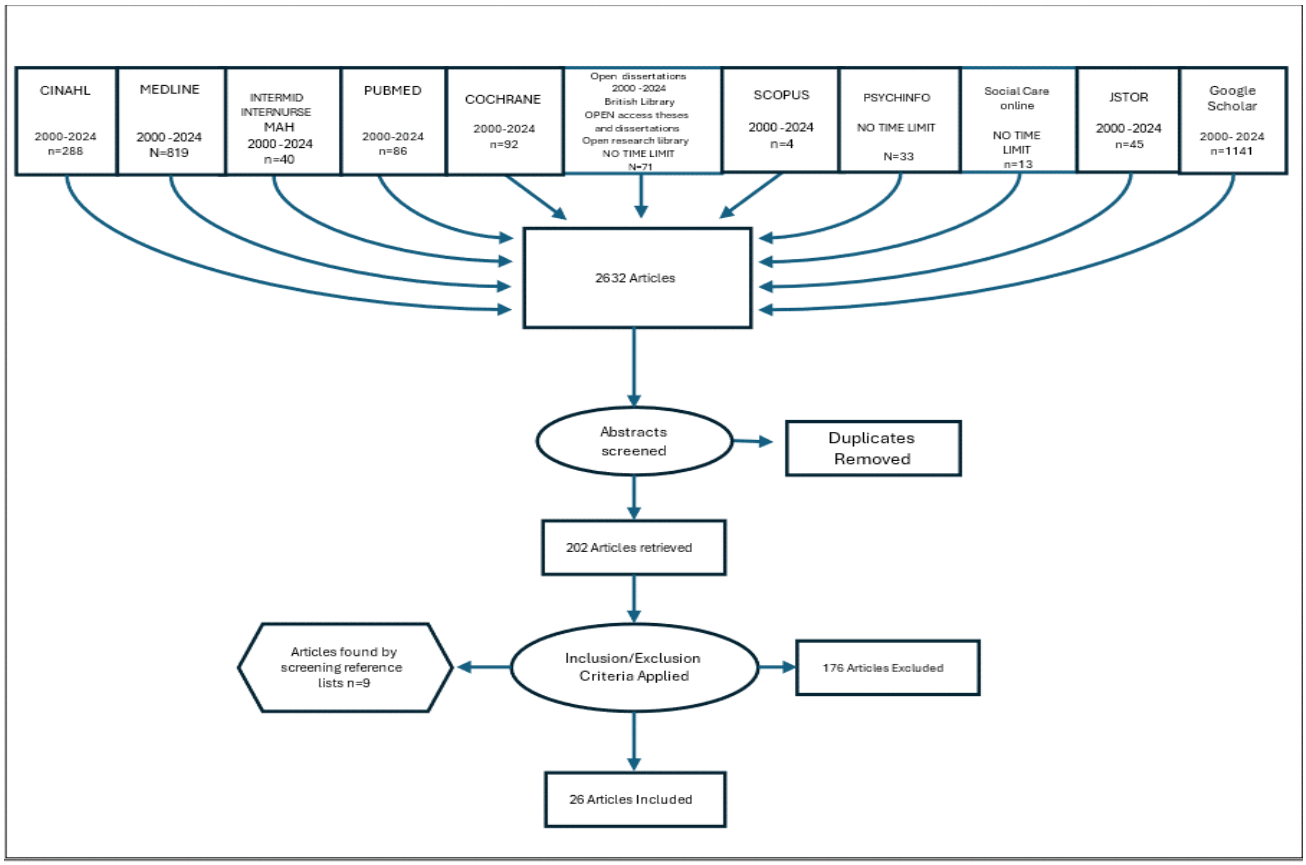
During the process of conducting the literature review, methodological considerations were undertaken regarding the inclusion and exclusion criteria (see table 3 1). A time frame of 2000 to 2024 was utilised to capture the first noted increase in mortality for Black African mothers in the CEMACH report for 2000-2002 (CEMACH, 2004, Knight et al., 2023). Editorial, commentary, and opinion pieces were omitted, and only primary or secondary studies were included. This was to ensure that the papers were of a high quality thereby increasing credibility. Peer and non-peer reviewed studies were included to avoid the loss of potential papers.

Table 3 1: Inclusion and exclusion criteria

Inclusion criteria	Exclusion criteria
Papers published after 2000	Papers published before 2000
Primary or secondary research, systematic or narrative literature reviews	Editorials, commentary, and opinion pieces
Papers that include migrant Black African women's or their healthcare providers experiences of antenatal care in any country or setting	Papers that do not include migrant African women's or their healthcare providers experiences of antenatal care
Outcomes or focus related to cultural competency	Outcomes or focus not related to cultural competency

A total of 2632 papers were retrieved from the initial searches. The removal of duplicates and screening of the titles and abstracts was undertaken to determine eligibility and irrelevant papers omitted reducing the number of papers to 202. The remaining papers were reviewed, and the inclusion/exclusion criteria applied. A review of the full text of each eligible paper was then undertaken. No assumptions were made about the ethnicity of the research participants and studies had to clearly state that the women included were Black African. In some papers, which included non-White ethnic women it was not stated that the research population were migrant African women, so these were excluded. A second review of the papers focused on migrant Black African women's experiences of routine antenatal care which were related to cultural competence either in the focus of interest or in the findings or recommendations. In addition, any papers that included healthcare provider's experience of providing routine antenatal care for migrant Black African women were also selected. A Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) format was utilised to show a diagrammatic summary of the screening process and to demonstrate transparency (Moher et al., 2009) (see table 4 1).

Table 4 1: PRISMA chart



The results were 26 full text papers, including 19 qualitative studies and seven literature reviews.

2.4 Quality Assessment of papers

The papers were examined utilising the Critical Appraisal Skills Programme (CASP) checklist, which assesses the trustworthiness, relevance, and results of studies (CASP, 2024). Key data was extracted from each paper (see table 5 1). The qualitative studies were assessed for clear research aims, appropriate methodology, recruitment strategy, data collection methods, researcher /participant relationship, data analysis and relevance of results. The literature reviews were appraised by reviewing the type and relevance of papers included, if included studies were quality assessed, preciseness of results and the outcomes. This process facilitated the analysis of the findings from each study and the limitations and strengths. The CASP tool is reported to be a good measure of transparency of the research methods and reporting standards in studies, however quality appraisal is reliant on what is reported (Long et al., 2020). Therefore, a study which was conducted well may be deemed to be poor quality due to omissions in the published paper. CASP states that they do not use a scoring system but advise that if the reviewer is unable to answer 'yes' to the first two to three questions on clear research aims, appropriate methodology and appropriate research design for qualitative studies then the quality of the research is poor. The same principles of quality apply to systematic reviews whereby if there is not a clearly focused question, or right type of papers are not searched for or included, then this signifies poor quality.

The quality appraisal revealed that fifteen of the qualitative studies were of a good quality, in four studies the data analysis process was unclear, and in one of these studies there was limited rationale given for the data collection methods. There were no studies found that explored migrant Black African women or midwives' perspectives of cultural competency in antenatal care. In addition, there was a paucity of studies that included both migrant Black African women and midwives' perceptions of cultural competency in antenatal care. A majority of the studies utilised a non-specified qualitative approach with the data reviewed utilising thematic analysis, four studies adopted content analysis. The terms migrant, immigrant, refugee and asylum-seeking (see glossary) were used interchangeably in the literature. There were only three studies that explored the cultural beliefs that were important in pregnancy for migrant Black African women, and this was in the United States of America (USA) with a homogenous group of Somali women (Hill et al., 2012), the UK with migrant Nigerian mothers (which included midwives perspectives of mother's cultural needs) (Dike, 2019) and Greece with 42 Black African women from the Congo, Ghana and

Cameroon (Sarantaki et al., 2020). The remaining studies explored women's experiences of pregnancy care. Four of the qualitative studies only sought the views of Somali women with one study exploring Somali women and healthcare professionals' experiences (Bulman and McCourt, 2002), and another study included the views of Somali men and women (Wojnar, 2015). The remaining studies explored the pregnancy experiences of other migrant Black African women (n=5) and healthcare professionals' experiences of caring for migrant Black African women (n=6).

It was important to include systematic and narrative reviews in this review as there was a dearth of papers that focused on migrant Black African women's perceptions of cultural competency in antenatal care or their cultural practices or of midwives' perceptions of cultural competency. Inclusion of narrative reviews ensured that unique and various perspectives from diverse disciplines were not omitted (Sukhera, 2022). All seven literature reviews had strengths and limitations, and all were of good quality. One review was a qualitative metasynthesis (Shorey et al., 2021), five were systematic reviews (Azugbene, 2023; Balaam et al., 2013; Esegbona- Adeigbe, 2018; Fair et al., 2020; Higginbottom et al., 2019; and one was a narrative review (De Freitas et al. 2020). Two of the systematic reviews did not report or utilise a quality appraisal tool for the included papers. One narrative review only researched two databases with thirteen studies selected and did not conduct a quality appraisal (DeFreitas et al., 2020). Two of the reviews that used a quality appraisal tool, reported that all studies included were of good quality (Balaam et al., 2013; Shorey et al., 2021). Higginbottom et al. (2019) reported that 12 out of 40 studies included in their review were assessed as being of low quality. Fair et al. (2020) stated that 18 out of the 51 studies in their review were rated as poor quality. The literature reviews were conducted on studies in the USA, Portugal, Europe (2) and the UK (2) and one review that was Worldwide, thereby providing an international perspective. All of the reviews included migrant African women, although in one study it was unclear which countries the women were from. Some strengths of the literature reviews included use of multicultural researchers or a multidisciplinary research team (Balaam et al., 2013; Fair et al., 2020). Three reviews included qualitative, quantitative, and mixed methodology (DeFreitas et al., 2020; Esegbona-Adeigbe, 2018; Higginbottom et al., 2019). Two of the systematic reviews excluded quantitative studies (Balaam et al., 2013; Shorey et al., 2021). Recommendations for assessing quality in literature reviews is more relevant to meta synthesis rather than narrative reviews. Furthermore, excluding studies that did not follow the common methodological standards, I believed could lead to the exclusion of pertinent information. However, to strengthen the reliability of this systematic review CASP was used, however no papers were rejected through this process if they met the inclusion criteria.

Table 5 1: Summary of selected papers

Title	Type of study/ Country/ sample	Findings	Strengths	Limitations	Recommendations
Aquino, M. R. J. V., Edge, D., & Smith, D. M. (2015). Pregnancy as an ideal time for intervention to address the complex needs of Black and minority ethnic women: Views of British midwives. Midwifery, 31(3), 373-379.	Qualitative study semi structured interviews/Thematic analysis/ 20 midwives UK	Language barriers Complex needs Extending beyond maternity care	Maximum variation sampling strategy	Interviewers not midwives Midwives from one NHS Trust	Research to include perspective of service user and care givers Midwives trained in cultural or religious practices
Azugbene, E. A. (2023). Maternal health experiences and health care utilization of African immigrant women: A review of the literature. Maternal and Child Health Journal, 27(8), 1324-1334.	Systematic review USA	Predisposing factors of health belief, knowledge, and literacy Dissatisfaction with obstetric interventions due to cultural beliefs	Several large databases utilised	13 studies of which 10 included only Somali women No quality appraisal	Health promotion and health education strategies emphasising culturally competent communication and acceptable providers with specific skills

Azugbene, E. A., Cornelius, L. J., & Johnson-Agbakwu, C. (2023). African immigrant women's maternal health experiences in Clarkston, Georgia: A qualitative study. Women's Health Reports (New Rochelle, N.Y.), 4(1), 603-616.	Qualitative study Semi structured interviews/Thematic analysis 14 African immigrant women < 6 years in USA/ Congo (3) /Sudan (6)/ Ethiopia (1)/ Eritrea (2) Egypt (1)/ Nigeria (1)	Immigrant refugee mothers struggle with living between two cultures Limited English proficiency Need for better health education Different treatment from health providers Fear of medication and obstetric interventions	Variety of countries included	Views of health care providers not sought	Studies of interventions implemented to facilitate easier navigation and assimilation of maternal health care for African immigrant women Need for culturally competent maternal health care and models of maternity care
Balaam, M., Akerjordet, K., Lyberg, A., Kaiser, B., Schoening, E., Fredriksen, A., . . . Severinsson, E. (2013). A qualitative review of migrant women's perceptions of their needs and experiences related to pregnancy and childbirth. Journal of Advanced Nursing (John Wiley & Sons, Inc.), 69(9), 1919-1930.	Systematic review – Europe	Lack of connection to healthcare professional and society Migrant women exposed to high degree of stress and vulnerability	Multicultural research group	Quantitative studies not included Sixteen studies European focus only	Maternity services must be adapted to migrant women's expectations of support and cultural differences
Bulman, K. H., & McCourt, C. (2002). Somali refugee women's experiences of maternity care in west London: a	Case study/ UK	Inadequate provision of interpreting services	Use of Somali interpreter who had	Small case study	Integrated Language services

case study. *Critical Public Health*, *12*(4), 365-380.	Semi structured interviews and / 12 Somali women Healthcare professionals	Lack of understanding from staff of cultural differences	knowledge of health issues	Data analysis approach unclear	Education of healthcare professionals on caring for a multicultural society
Carolan, M., & Cassar, L. (2010). Antenatal care perceptions of pregnant African women attending maternity services in Melbourne, Australia. Midwifery, 26(2), 189-201.	Qualitative Exploratory study/ Thematic analysis In depth interviews 18 Pregnant first-generation Africans/ Mostly from Horn of Africa and Sudan	Resettlement is a priority. Childbirth is a normal process Cultural sensitivity is important Pregnancy viewed as not special	Researcher reviewed Dinka and Amharic cultures and spent several weeks in African clinic prior to recruitment	Only one interview was audio recorded the rest had notes taken	Women require access to services are sensitive and accommodating of their cultural beliefs and practices. Further research on information needs
De Freitas, C., Massag, J., Amorim, M., & Fraga, S. (2020). Involvement in maternal care by migrants and ethnic minorities: A narrative review. Public Health Reviews, 41, 5.	Narrative review Worldwide	Migrant women lack access to adequate knowledge due to misconceptions Less involvement in care due to difficulties in understanding socio-cultural beliefs	Included qualitative, quantitative and mixed methodology. Backward referencing utilised	Only two databases 22 studies No quality appraisal	More research needed on how to tailor various dimensions of involvement to migrant and ethnic minorities needs and preferences

					Further enquiry into healthcare staff beliefs, expectations, and attitudes
Degni, F., Suominen, S., Essén, B., El Ansari, W., & Vehviläinen-Julkunen, K. (2012). Communication and cultural issues in providing reproductive health care to immigrant women: health care providers' experiences in meeting Somali women living in Finland. Journal of immigrant and minority health, 14, 330-343.	Qualitative study/ content analysis/ Finland Interviews and focus groups/ 10 Gynaecologists/Obstetricians/ 15 nurses and midwives	Communication and cultural sensitivity important in providing reproductive health care Professionals had limited knowledge about women's culture	Views from different reproductive health care professionals	Large focus group of six nurses, eight midwives/ 1 psychiatric nurse	Specific training for health care professionals on how to interact with women from different cultural and religious backgrounds
Degni, F., Suominen, S. B., El Ansari, W., Vehviläinen-Julkunen, K., & Essen, B. (2014). Reproductive and maternity health care services in Finland: Perceptions and experiences of Somali-born immigrant women. Ethnicity & Health, 19(3), 348-366.	Qualitative study/ Concepts of cultural care used for analysis/ Finland 5 focus groups/ 70 Somali women	Poor communication and unfriendliness	Large sample Saturation	Three focus groups numbers high (15, 17 and 20)	Women's perceptions are important for healthcare professionals to achieve culturally competent care
Dike, P. (2019). Does culture influence birth experiences of first-generation Nigerian women in London. International Journal of Nursing and Midwifery, 11(8), 87-102.	Exploratory, descriptive contextual study/UK	Beliefs, religion, and spirituality influence birth experiences	Interviews with mothers at 24 weeks, 3 and 6 months postnatally	No information on length of time in UK	Provision of culturally congruent care

	Focus groups with 18 mothers and 12 midwives One-to-one interviews with six mothers Thematic analysis	Discrepancy in expectations Acculturation and migration militate against care access and transition to mother			
Esegbona-Adeigbe, S. (2018). Cultural qualities and antenatal care for Black African women: A literature review. British Journal of Midwifery, 26(8), 532-539.	Systematic review/ Worldwide	Cultural factors impact on antenatal care provision	Qualitative, Quantitative and mixed methodology papers included 16 studies	Quality appraisal tool not discussed	Consideration of women's cultural beliefs and practices during antenatal care provision is required
Fair, F., Raben, L., Watson, H., Vivilaki, V., van den Muijsenbergh, M., Soltani, H., & ORAMMA team. (2020). Migrant women's experiences of pregnancy, childbirth, and maternity care in European countries: A systematic review. *PloS one*, *15*(2), e0228378.	Systematic review/ Europe	Lack of understanding between migrants and healthcare professionals in terms of traditional customs and expectations of maternity care impact on access	Multidisciplinary research team 51 studies/ 18 of poor quality	Definition for migrant not provided/papers from 14 different countries	Culturally competent and trauma informed mode of maternity care required.

Goberna Tricas, J., Vixas Llebot, H., PalacioTauste, A., Galt García, M., Pault Cabezas, À, & Gómez Moreno, C. (2005). Prenatal care in African immigrants. the perception of primary care midwives. Enfermería Clínica, 15(2), 88-94.	Observational descriptive study, Spain/ SPSS analysis/ Self-completed questionnaires 19 midwives who had cared for Senegal and Gambian women	Communication difficulties impacted of care delivery Midwives wanted training in culture and customs	19 out of 102 midwives had cared for African immigrants	Unclear data analysis process	Cultural mediators Knowledge of culture and diversity as Continuous Professional Development (CPD) and during training.
Higginbottom, G. M. A., Evans, C., Morgan, M., Bharj, K. K., Eldridge, J., & Hussain, B. (2019). Experience of and access to maternity care in the UK by immigrant women: A narrative synthesis systematic review. BMJ Open, 9(12).	Systematic review, UK narrative synthesis	Lack of language support, cultural insensitivity, discrimination, poor relationships between immigrant women and healthcare providers	40 studies included/ quality appraisal 12 studies low quality	Did not differentiate between refugees, asylum seekers and immigrants	Addressing language barriers and ensuring culturally sensitive care Mandatory education on cultural awareness
Hill, N., Hunt, E., & Hyrkäs, K. (2012). Somali immigrant women's health care experiences and beliefs regarding pregnancy and birth in the United States. Journal of Transcultural Nursing : Official Journal of the Transcultural Nursing Society, 23(1), 72-81.	Qualitative study Thematic content analysis/ USA Four Focus groups- each 4-7 women/ average six years in USA Somali women	More trust in Allah not in science/New experiences and information was integrated with own cultural, religious, and scientific beliefs	Researchers had one year of experience working with Somal and other refugee populations Member checking used	Some data loss during focus groups due to women talking simultaneously	Development of Somali specific workshops for healthcare providers Development of educational material by interpreters, cultural brokers, advisors Increasing opportunity for shared decision making

Konje, J. K., & Konje, J. C. (2021). Experiences of accessing maternity care in the UK: Perspectives from Somali migrant women in Leicester. European Journal of Midwifery, 5.	Qualitative study/ UK Constant comparison method 2 Focus groups/ 5 Individual interviews	Language difficulties Cultural awareness Trust and continuity of care Personal, community and religious beliefs and views	Homogenous group	Small sample	Independent professional interpreters who are culturally trained/ Community based discussion groups Continuity of carer/ Midwives offered mandatory in-depth training on cultural diversity
Lyons, S. M., O'Keeffe, F.,M., Clarke, A. T., & Staines, A. (2008). Cultural diversity in the Dublin maternity services: The experiences of maternity service providers when caring for ethnic minority women. Ethnicity & Health, 13(3), 261-276.	Grounded theory/ Ireland Five Focus groups (each 5-7) of midwives and maternity auxiliary nurses/ 15 Interviews with obstetricians	Women expected to adapt to maternity services Participants recognised deficiency in their knowledge and need for education regarding cultural issues	Saturation achieved	Not clear which data was specifically from the obstetricians or midwives/auxiliary nurses	Move to a more multi-cultural approach in maternity services
Mohale, H., Sweet, L., & Graham, K. (2017). Maternity health care: The experiences of sub-Saharan African women in sub-Saharan Africa and Australia. Women & Birth, 30(4), 298-307.	Qualitative/Australia/thematic analysis/ Australia 14 semi structured interviews 11 Sub Saharan African women	Perceptions of needs and desire for healthcare is influenced by individuals' health literacy, health beliefs, trust, and expectations	Saturation achieved	Possible recall bias Participants from six countries	Attending to factors that that affect access to care in terms of perceiving need, seeking, reaching, and utilising care

		Women experienced empowerment and disempowerment			
Murray, L., Windsor, C., Parker, E., & Tewfik, O. (2010). The experiences of African women giving birth in Brisbane, Australia. Health Care for Women International, 31(5), 458-472.	Phenomenological/ semi structured interviews 10 women/less than five years in Australia	Feeling alone and feeling different Lack of time Lack of cultural knowledge and understanding	Use of bilingual worker during interviews	Not clear which countries women were from Data analysis approach unclear	Cross cultural training for clinicians
Oscarsson, M. G., & Stevenson-Ågren, J. (2020). Midwives' experiences of caring for immigrant women at antenatal care. *Sexual & Reproductive Healthcare*, *24*, 100505.	Qualitative study Content analysis Five focus groups One individual interview/ Swedish midwives	Communication improved by trust, educational status, and previous experience of woman	Midwives had extensive experience of caring for immigrant women	All Midwives Swedish in origin	Culturally appropriate communication required. Support required for midwives
Sarantaki, A., Metallinou, D., Kyritsi, R., Diamanti, A., & Lykeridou, K. (2020). Perinatal cultural aspects of African refugee women resettled in Greece: Providing culturally sensitive	Cross sectional study Questionnaire answered with face-to-face interviews/Greece	Providing midwifery through a cultural lens is of great importance	Large sample	Rationale for data collection not provided	Increased understanding of African perinatal cultural aspects is essential

midwifery care. Materia Socio-Medica, 32(4), 294-298.	42 African women (Congo, Ghana, Cameroon)			Data analysis process unclear	Awareness of barriers, cultural insight/ family members in decision making
Shorey, S., Ng, E. D., & Downe, S. (2021). Cultural competence and experiences of maternity health care providers on care for migrant women: a qualitative meta-synthesis. *Birth*, *48*(4), 458-469.	Qualitative meta synthesis/UK Healthcare providers' view	Cultural blindness Conflicting care expectations	Quality appraisal / All 11 studies included of good quality	Limited to Qualitative studies	Maternity health providers need capacity in cultural care negotiations CPD on cultural competencies
Strauss, L. Mc Ewan, A. & Hussein, F, M. (2009). Somali women's experience of childbirth in the UK: perspectives from Somali health workers, Midwifery 25(2), 181-6.	Qualitative study Ethnographic narrative approach In depth interviews Thematic analysis Eight health care workers	Communications issues Lack of knowledge of FGM Different expectations of pregnancy care Pressures from migration experiences	Women provided dual experiences of health care worker and service. User	Not a homogenous group of health professionals	Culturally acceptable communication Increase knowledge of FGM/ migration experiences Continuity of care
Tobin, C., Murphy-Lawless, J., & Beck, C. T. (2014). Childbirth in exile: Asylum seeking women's experience of childbirth in Ireland. *Midwifery*, *30*(7), 831-838.	Qualitative /Pentad Narrative analysis/ Ireland Unstructured interviews/ 22 women asylum seeking/refugee - nine countries, majority from Nigeria (n=14)	Lack of connection, communication, and cultural understanding	Participant involvement in design of the study/ member checking	Heterogenous sample eight women from different countries in Africa, Iran, and Iraq.	Further research looking at childbirth education needs of ethnic minority women Mandatory training in cultural competency

					Twenty-four hours access to interpreters
Tobin, C. L., & Murphy-Lawless, J. (2014). Irish midwives' experiences of providing maternity care to non-Irish women seeking asylum. *International journal of women's health*, 159-169.	Qualitative study Semi structured interviews with ten midwives Content analysis	Communication barriers Cultural differences	Second researcher for data analysis Cared for women from six different Black African countries	Small scale study	Develop an understanding of diversity and issues that contribute to understanding of culture Cultural humility In service cultural competency training
Wojnar, D. M. (2015). Perinatal experiences of Somali couples in the United States. Journal of Obstetric, Gynecologic, and Neonatal Nursing : JOGNN, 44(3), 358-369.	Descriptive phenomenology / USA Colaizzi analysis Semi structured individual interviews/ interviews with couple/ follow up phone interview 26 Somali women and 22 Somali men/ last 5 years in USA	Cultural beliefs, values and customs shaped how participants interpreted, responded, and judged healthcare professional's actions and words. Need for unconditional respect for Somali otherness	Individual and couple interviews Follow up interviews	Variation in study participants	Culturally appropriate prenatal programs Individual supportive interventions Special attention to most recent immigrants Inclusion of men in perinatal care

2.5 Synthesis

Thematic synthesis was used to derive themes from the selected papers, which involved three stages (Thomas & Harden, 2008). The first stage involved coding of data, by reading each paper line by line and focusing on the results. A summary of each paper's findings and recommendations were created, maintaining the essence of what was reported. The second stage involved comparing the findings from each paper leading to the development of descriptive themes which remained close to the studies. During this process, some new codes were created or names of existing codes changed to avoid overlapping of information. A process of reviewing which codes were dominant across the papers was undertaken, which was useful to see which codes were conceptually similar and could be grouped together into descriptive themes (Damarell et al., 2020). Stage three involved creating analytical themes which represented my interpretation of the data and addressed the phenomenon of interest (Thomas & Harden, 2008). I had planned to review the papers using the constructs of cultural competency, but the studies did not directly address these elements, making it difficult to code and theme the data. However, the components that demonstrated cultural competency were looked for in the descriptive themes which guided the labelling of the analytical themes.

2.6 Literature review results

The next sections appraise the systematic and narrative literature reviews followed by an analysis of the primary studies and the grey literature. The review of the primary studies is discussed utilising common themes and findings. This is a recommended process which provides a clear structure for reporting the findings of a literature review (Carnwell & Daly, 2001).

Systematic and narrative reviews of migrant Black African women and their healthcare providers' perceptions of antenatal care

Esegbona-Adeigbe (2018) conducted a systematic review with the aim of exploring specifically the cultural qualities important to Black African women during antenatal care and healthcare provider's views when providing care. There was no restriction on the methodology used in the studies, or the setting, thereby increasing the scope and breadth of the review (Moher et al., 2015). This review included 16 qualitative studies, retrieved from six databases. Cultural needs were found to shape women's maternity needs and knowledge of these cultural factors were found to be required by health professionals to achieve cultural competency/sensitivity. This review focused on cultural

competency which differed to other selected studies which were generic in exploring the experiences of Black African women during pregnancy. Esegbona-Adeigbe (2018) compared cultural views of migrant and non-migrant Black African women and revealed that cultural qualities were important in determining women's views of quality antenatal care regardless of the context. However, the limitations of this review were the merging of Black African women's experiences in their own country and the diaspora, which would pose difficulty in extrapolating recommendations relevant to migrant Black African women in the UK (MacMillan et al., 2019). This review highlighted the importance of cultural factors in antenatal care provision and the dearth of studies that explored what these cultural factors constituted. Esegbona-Adeigbe (2018) concluded that further research was required to extricate the cultural qualities that Black African women deemed to be important during antenatal care.

A narrative review with no limitation on the setting or methodology was conducted by De Freitas et al. (2020), adding further knowledge to Esegbona-Adeigbe's findings. De Freitas et al. explored migrant women's involvement in their maternity care. In total, 22 papers were included with migrant and non-migrant Black women, including 11 quantitative studies with most using a cross-sectional design. Only two databases were utilised with no rationale for this provided which may have restricted the potential to source relevant studies (Ferrari, 2015). This review's focus on user involvement meant that experiences of access and engagement with maternity care may have been obscured. Furthermore, as the inclusion criteria was for all ethnic minority and migrant women, individual views would be difficult to conclude due to variation of cultures across different contexts (Ahmadinia et al., 2022; Chauhan et al., 2020). De Freitas et al's study contrasted to Esegbona-Adeigbe's review, which was restricted to Black African women, however findings were similar demonstrating the issues faced by ethnic minority women regardless of country of origin. De Freitas et al's findings demonstrated that misconceptions about women's sociocultural needs were impacted by communication difficulties and healthcare provider's lack of cultural knowledge. De Freitas et al. echoed Esegbona -Adeigbe's findings that consideration of women's cultural beliefs should be factored into maternity care provision demonstrating the importance of culturally sensitive care. The similarities between Black African and non-Black African migrant women's health experiences were noted in this study, which has been found in other studies with other ethnicities (Espinoza et al., 2014; Toh & Shorey, 2023). Therefore, further exploration to decipher to what extent migration impacts on health seeking behaviour is warranted. De Freitas et al (2020) concluded that further research was required on healthcare provider's beliefs, expectations, and attitudes and how this influenced cultural competency.

A qualitative systematic review provided a European focus on migrant women perceptions of their needs and experiences during pregnancy and childbirth and their health needs and access to maternity services (Balaam et al., 2013). This review included 16 studies conducted in Sweden, the UK, Switzerland, Norway, Ireland, and Greece. It was noted that studies were not found from France, Italy or Spain, countries which historically have large populations of migrant Black Africans (European Union Agency for Fundamental Rights, 2023), which questioned if the breadth of the review was adequate. Only some of the studies selected included Black African women, mainly from Somalia, therefore, consideration should be given that some views were from women of other ethnicities. Thematic analysis by an interdisciplinary team, was a strength in Balaam's study but could also be a limitation due to possible conflict in consensus on the findings (Tobi & Kampen, 2018; Zhang & Wang, 2021), individual interpretations may have occurred within the analysis. Furthermore, reviewers with diverse views may have arrived at different conclusions, hence the need to meet a consensus may have led to relevant findings being omitted (Shanker et al., 2021).

Balaam et al. (2013) revealed migrant women's lack of connection to health care professionals and society and a high degree of stress due to their personal circumstances. This was not an unusual finding as high levels of stress have been reported in migrant women, especially if there is forced displacement due to war or persecution (Li et al., 2016; Sangalang et al., 2019). Of equal importance, were communication issues which led to a lack of understanding, impacting on the ability of women to ask midwives questions. It would have been useful to have further information on how the dominant Western medical philosophy and terminology reported by Balaam et al. created difficulties for migrant women leading to more trust in religion than technology when giving birth. There is acknowledged complex relationship between traditional and Western medicine, which could have been further discussed in this review (Cunningham & Andrews, 2017; MacLeod & Lewis, 2022). Breaking of traditional norms were reported by Balaam et al. as being an inherent vulnerability factor for women coupled with loneliness, stress, and anxiety of being a new migrant. Additional detail on the impact of attempting to adjust to a different culture whilst maintaining cultural practices was absence in Balaam et al's review, although it is argued that this is a common issue for migrant women (Benza & Liamputtong, 2014; Olajide et al., 2014). The sole use of qualitative studies in this review would have assisted in a deeper analysis of the experiences of migrant women when utilising pregnancy care in a new country however, insufficient data was reported on these aspects. Balaam et al. (2013) recommended adaptation of maternity services to meet migrant women's expectations in support and in acknowledgement of cultural differences.

A further qualitative and mixed methods systematic review with the same criteria as Balaam et al. was conducted seven years later by Fair et al. (2020), which focused on the pregnancy experiences of migrant women in European countries. This review added more recent evidence to Balaam et al's (2013) findings, and in contrast included studies from France, Italy, and Spain therefore, representing countries that had large populations of migrant Black Africans (European Union Agency for Fundamental Rights, 2023). The high number of studies (n=51) included in this review, demonstrated a broad inclusion criterion, papers on any aspect of migrant women's pregnancy experience were included. The substantial number of included studies strengthened this review (Hiebl, 2023); however, it is argued that quality of reviews can be impacted, and pertinent issues may remain hidden due to the need to analyse a large number of papers (Harari et al., 2020, Hiebl, 2023). Papers were subjected to a comprehensive review by two independent reviewers who utilised a quality assessment tool which was a strength of this review (Luchini et al., 2021). The studies included had researched a range of Black African women, from East, West and Southern African countries. Thereby, providing a broad perspective of migrant women's experiences from the whole of the African continent. However, it is argued that the infrastructure of maternity care provision differs across Europe (Batinelli et al., 2023; Coxon et al., 2020), and therefore, Fair et al's findings needed to be considered in the context of these variations. In addition, the period of migration was not evident in this review which limited the ability to link the impact of acculturation to women's experiences. Fair et al's findings showed that navigating pregnancy in a new place was impacted by lack of knowledge of the health system.

Fair et al. (2020) found that language barriers were also an issue with English speaking migrant women finding issues with understanding medical terminology. There was a limited discussion on how language difficulties contributed to conflicts with health advice from health care providers which left women feeling uncertain and vulnerable. Communication issues have been known to contribute to poorer health in pregnancy with women who do not speak the host country's language (Origlia Ikhilor et al., 2019). It has been demonstrated that communication barriers were not due to language proficiency but other linguistic factors in migrant women (Tankosic & Dovchin, 2023). Women felt they were treated differently and that care providers did not understand their customs and culture. How these issues were heightened by long waiting times and perceived busyness of health care providers was not evident in this review. It was noted that some women felt that there were good relationships with health care professionals who demonstrated cultural sensitivity whilst not necessarily having in-depth knowledge of women's customs and traditions.

This demonstrated the interplay between sensitivity and knowledge, in this study it was difficult to determine if in fact cultural knowledge was utilised to be more culturally sensitive. Cultural knowledge is stated to be the basis for culturally competent care (Esegbona-Adeigbe, 2011). Therefore, further consideration of this in Fair et al.'s study was required. Like Balaam et al. (2013), cultural competency training was recommended, in particular it was advised that health care providers needed to provide person-centred, high-quality care and continuity of care that incorporated aspects of cultural competency (Fair et al., 2020).

Higginbottom et al. (2019), explored the experiences of and access to maternity care by immigrant women in the UK. This narrative systematic review specifically contributed to the knowledge of migrant women's pregnancy experiences in the NHS. Furthermore, a review of the grey literature was included which would have assisted in the retrieval of papers outside academic channels. Grey literature is rated to make an important contribution to systematic reviews and can reduce publication bias and increase a review's comprehensiveness (Paez, 2017). Higginbottom et al. (2019), selected 40 papers with no restrictions on methodology. Sixteen of the studies did not state the ethnic group of participants and the researchers assumed that requirements for an interpreter suggested that the women were born outside the UK, however, this view could be met with scepticism. However, the women were either migrants, asylum seekers or refugees. Fourteen studies did not state country of origin for migrant women which limits the potential to utilise recommendations for other migrant Black African women. However, in the remaining studies it was clear that Black African women's perspectives were included. The studies reviewed covered the whole of the UK apart from Northern Ireland, with 14 studies conducted in London. In four studies it was unclear in which part of the UK the study was situated. Therefore, caution needed to be taken regarding attributing findings to other parts of the UK, due to lack of details regarding the sample in the studies selected (Berndt, 2020, Gill, 2020).

Higginbottom et al. (2019), found that migrant women booked late for antenatal care which was influenced by lack of knowledge of the services. Consideration was not given to other causes that could contribute to late attendance for antenatal care, as it could be argued that access would be different for asylum seekers and refugees compared to women who migrated for socioeconomic reasons (Knight et al., 2020; 2023). There were positive and negative views of health care professionals, with reports that women's social and psychological needs were met but in contrast women experienced discriminatory behaviour or insensitivity to their cultural and social needs.

Communication challenges was persistently reported, in particular use of complex terminology or professional language, and misunderstanding of facial expressions and gestures, indicating lack of cultural sensitivity and skill (Campinha-Bacote, 2002). Immigrant women reported that healthcare professionals had limited knowledge on Female Genital Mutilation (FGM), and that antenatal care was medicalised. Organisational factors were reported in several of the selected studies, including lack of continuity of care and being refused care due to refugee status and arriving in the UK in the latter stages of pregnancy resulting in interruptions in women's care. Higginbottom et al. (2019) stated that maternity care staff required mandatory training focused on cultural awareness and the needs of diverse women including recent immigrants.

A qualitative meta synthesis specifically explored the cultural competence and experiences of maternity health care providers who cared for migrant women (Shorey et al., 2021). Campinha-Bacote's (2002) model of cultural competency was the theoretical lens used for this review guided by Carroll et al's (2013) best fit framework which was useful in focusing the review of the findings and addressing the review aims. Carroll et al's framework requires identification of a theory or conceptual model which is used to form the themes of a priori framework. A systematic review of the literature is then undertaken and included studies are then coded against the themes of the priori framework (Carroll et al., 2013). This increased the robustness of the review (Hielb, 2023) and assisted in the incorporation of diverse views. Shorey et al. (2021), was the only review found that focused on cultural competency of maternity care professionals thereby adding new knowledge. Eleven papers were selected for this review, published between 2011 and 2020, and included healthcare providers from Europe, Canada, and Australia. No studies in the final selection were conducted in the UK, indicating the lack of research in this area. None of the studies included evidence related to cultural skill, an ability to collect relevant cultural data or perform cultural assessments (Campinha-Bacote, 2002), demonstrating a gap in the evidence. In this instance, widening of the inclusion criteria to include any papers that included assessment of migrant populations may have addressed this deficit. Shorey et al's (2021) findings showed that health professionals viewed migrant women as 'other', revealing their awareness of differences but seeing migrant women as a homogenous group with no consideration of the subjectivity of the individual. The term 'cultural blindness' was stated as upholding the belief that the dominant culture should take precedence regardless of an individual's culture. It can be argued that there is a thin line between 'cultural blindness' and othering' and so further exploration of the differences could have been included in this report. Continuous professional education on cultural

competency, provision of ethnically diverse staff and translated resources were recommended by Shorey et al. (2021).

A non-European perspective was reported by Azugbene (2023), in a qualitative systematic review focused specifically on migrant Black African women's experiences and utilisation of maternal health services in the USA. Thirteen studies were selected for this review, with 11 studies only including Somali women. The remaining two papers included Congolese and Sudanese women. This demonstrated the paucity of studies in the USA, which focused on other African migrants, despite the 1.9 million African born migrant population reported in 2019 (Pew Research Centre, 2022). Azugbene (2023) found that migrant Black African women did not seek health advice until they were ill, the cultural belief was that health advice should only be sought if symptoms were severe. Cultural traditions of using herbal remedies and religious healing ceremonies were reported in four studies. As this review highlighted women's reliance on cultural practices rather than Western medicine, it would have been useful to draw further conclusions on why this was so. Several studies reported health literacy, health beliefs and lack of health knowledge as being barriers to engagement with maternal health services. Revealing the multifaceted factors that affect migrant Black African women, similar to other studies in Europe and Worldwide (De Freitas et al., 2020; Fair et al., 2020). However, limited availability of studies that explored other African women, meant that this could not be examined further. Migrant women reported positive and negative experiences with healthcare providers such as respectful and compassionate care and disrespectful treatment, racism, prejudice, and bias. These findings were similar to Higginbottom et al's (2019) review of immigrant women in the UK. Due to a majority of studies on Somali women in Azugbene's (2023) review, the views of these participants may have differed to other migrant Black African women. Azugbene (2023) acknowledged the paucity of studies on other African populations, however cultural competency was the emphasis in the recommendations of health promotion and health education strategies to address the issue of stigma and reinforcing culturally competent communication for migrant African women.

2.7 Studies on migrant Black women's experiences of maternity care

The themes derived from the synthesis of the 11 qualitative studies which included the views of migrant Black African women were: Cultural and religious beliefs versus Western medicine, Lack of cultural sensitivity and cultural understanding, Pregnancy seen as a normal process, Cultural

expectations and challenges and Language differences. The following sections analyse these themes.

Cultural and religious beliefs versus Western medicine

Two studies conducted in the USA and one study in the UK found that migrant Black African women placed more value on their cultural practices rather than Western medicine during pregnancy. Migrant Somali women were researched by Hill et al. (2012), who focused on their cultural beliefs regarding pregnancy and childbirth. This was a generic qualitative study that conducted four focus groups, each consisting of four to seven women who had lived in the USA for an average of six years. It is argued that if the sample is homogenous then a smaller sample is required for saturation to be achieved, so four to eight focus groups is deemed to be adequate (Hennink & Kaiser, 2022). Hill et al. (2012) utilised thematic content analysis to review the data, which is acknowledged to be an objective and systematic means of describing the phenomenon (Graneheim & Lundman, 2004). Three reviewers analysed the data which can improve confirmability and reduce researcher bias (Connelly, 2016). In addition, open coding and major themes were named using content characteristic words, therefore the words of the women were preserved, further strengthening trustworthiness (Ahmed, 2024). It was admitted by Hill et al. that some data was lost during the focus groups, as women were talking simultaneously, however, credibility was maintained by member checking to confirm that the findings represented their views (Kyngas et al., 2020). The study findings showed that women had more trust in their religious beliefs, demonstrating an integration of culture and religion being adhered to rather than scientific evidence. Some women did value Western medicine particularly if they had complications in their pregnancy such as gestational diabetes or hypertension. The focus groups would have been beneficial in exploring women's views; however, interviews may have elicited further detail about why specific cultural practices were adhered to, as this was absent in the findings. It was evident from the vignettes that Somali women wished to adhere to their cultural norms and practices whilst living in the USA. This study explored women's views of the whole pregnancy continuum however, the narratives showed that their experiences were applicable to all aspects of their pregnancy care. Cultural knowledge workshops were recommended for healthcare providers as well as development of educational material by interpreters or cultural brokers (Hill et al., 2012).

A phenomenological study that investigated perinatal experiences of Somali couples in the USA, found that cultural beliefs and values shaped health seeking behaviour and acceptance of health

professional's advice during pregnancy (Wojnar, 2015). This study used semi structured interviews with individual women and couples and Colaizzi analysis which allows for the revealing of emergent themes and their interwoven relationships (Morrow et al., 2015). Therefore, a detailed understanding of the participant's views was elicited. The participants, 26 women and 25 men had been in the USA for a period of less than five years, so views of recent migrants were retrieved, which was important in determining if length of migration impacted on adherence to cultural values. Follow-up interviews were conducted with couples after two weeks to clarify any findings, which strengthened the trustworthiness of the findings (Polit & Beck, 2020). It is argued that follow-up interviews may create challenges in data analysis and undermine data collected in earlier interviews (Ryan et al., 2016). Therefore, when reviewing the findings this needed to be considered, although Wojnar stated that no changes were made after review by participants. Follow-up interviews could also be seen as a form of member checking which increases credibility (Connelly, 2016). Wojnar (2015) found that participants disregarded health advice and adhered to traditional customs and beliefs.

The psychological impact of participants feeling vulnerable, misunderstood, and lonely when trying to navigate pregnancy in a dominant culture was evident in Wojnar's study and warranted further exploration. Although, there were negatives experiences reported due to lack of knowledge of some healthcare providers of Somali customs, this was not the case for all participants. Deep gratitude was expressed by some participants who encountered healthcare providers who had considerable knowledge of Somali culture or showed interest in learning about differences, leading to participant's acceptance of health advice (Wojnar, 2015). Therefore, there were mixed responses from women of their pregnancy experiences, but further examples of any positive interactions would have been useful. Other aspects of Wojnar's study added new knowledge, due to inclusion of the views of men which provided a different and under researched perspective compared to other studies conducted which only included Somali women's pregnancy experiences in the USA. Charsley and Wray (2015), highlighted the phenomenon of the invisible migrant man, stating that men remained marginalised as much as women, warranting further studies in this area. Wojnar's (2015) study highlighted the importance of involving men in perinatal care provision as it was revealed that they were interested in sharing women's experiences. More interestingly, was the revealed connection of shared cultural values between migrant women and their husbands, rather than as stated by Charsley and Wray (2015), men being viewed as oppressors of women to adhere to culture. Recommendations supported both women's and men's needs with particular

attention to recent migrants in the provision of culturally appropriate prenatal programmes to improve Somali parent's engagement with perinatal services (Wojnar, 2015).

Dike's (2019), exploratory, descriptive, and contextual UK qualitative study was conducted using focus groups with 18 first generation Nigerian mothers and 12 midwives to explore birth experiences, cultural practices, and cultural needs. Dike's findings were similar to those from Hill et al. (2012) and Wojnar's (2015) studies with Somali women revealing that first-generation Nigerian mothers valued their cultural and religious practices which impacted on their expectations of pregnancy care. Dike (2019) reported similarities and congruences between mother's and midwives' expectations. Information from the focus groups were used to guide the questions in semi structured interviews with six migrant Nigerian mothers at 24 weeks gestation, and three and six months postnatally. The emphasis in the interviews was to gather the cultural practices and needs of Nigerian women. The sample size for the interviews was small as it is argued that a minimum of nine to seventeen interviews are required to ensure adequate data is collected on the phenomenon (Hennink & Kaiser, 2022). This was a homogenous sample, and it is suggested that six interviews were sufficient in this context (Guest et al., 2006). Furthermore, the repeat interviews adopted by Dike is stated to contribute to nuanced data, increases reflexivity and promotes trust and rapport (Goyes & Sandberg, 2024; Roos, 2022). However, a disadvantage is the risk of losing participants and issues with recruitment (Goyes & Sandberg, 2024). This was reported by Dike (2019), as out of thirty women approached only six agreed to be interviewed. The exclusion of women with complicated pregnancies may have limited recruitment and impacted on relevance of findings to other settings (Burchett et al., 2013), although Dike stated that all women approached had no pregnancy complications.

One of the focus groups in Dike's (2019) study, was unintentionally only conducted with midwives of Nigerian ethnicity (n=4). The other group consisted of non-Nigerians (n=8). It was not disclosed if this group contained Black or White midwives, information that could have illuminated the impact of ethnicity on the discussions. Homogenous focus groups have been found to make more controversial comments relating to ethnic differences as they may be more at ease with each other (Greenwood et al., 2014). Therefore, there was a potential to have a deeper discussion on issues around ethnicity and cultural practices in the focus group with only Nigerian midwives. Although, if there is a shared interest, this may not be an issue in heterogenous focus groups (Gill et al., 2008). Women's length of time in the UK was not recorded or considered in the inclusion criteria, which

would have been useful to determine if acculturation had any impact on maintenance of cultural practices. Dike (2019) did not specifically focus on the triad of recent migration, culture, and antenatal care utilisation. Although, the cultural care practices and influences of first-generation Nigerian mothers, throughout pregnancy were investigated, Dike did not explicitly connect the continuance of cultural practices to period of migration. This would have provided further insight into the mother's migration experiences and how this impacted on their access to and engagement with maternity care.

Dike (2019) revealed the importance of cultural awareness, cultural sensitivity, and cultural knowledge to Nigerian mothers. The utilisation of Leninger's (2002) cultural care theory in Dike's study involved understanding and respecting mothers' culture when providing healthcare and identifying the need to maintain cultural practices or accommodating needs or restructuring of care. Therefore, the constructs of cultural skill, cultural encounters and cultural desire were not addressed whilst exploring the emic views of the Nigerian mothers. Perceptions of these constructs would have provided a holistic view of mother's experiences and strengthened the recommendations for a Cultural Care Midwifery Module particularly, for recently migrated women. The etic views of midwives in relation to caring for first generation Nigerian mothers were revealed in Dike's study. Papadopoulos et al's (1998), cultural competency model was used to guide the investigation of midwives' perceptions which addresses the constructs of cultural awareness, cultural sensitivity, and cultural knowledge. However, Dike did not directly state how these constructs were addressed or explored, meaning that midwives' perceptions were not fully investigated. Papadopoulos et al's model does not include the constructs of cultural skill, cultural encounters, and cultural desire, which is argued to be essential elements in achieving cultural competency (Campinha-Bacote, 2002). Dike's findings did not examine midwives' cultural skill, cultural encounters, and cultural desire, nor were they alluded to in the study's outcomes. Overall, Nigerian mothers' and midwives' perceptions of cultural skill, cultural encounters, and cultural desire and how they contribute to antenatal provision was absent in Dike's findings.

Lack of cultural sensitivity and cultural understanding

Two studies conducted in the USA and Australia found lack of cultural sensitivity and limited cultural understanding from healthcare professionals. A qualitative study exploring maternity care experiences with 14 migrant Black African women mainly from Sudan and Congo, and one Nigerian woman who had been in the USA for less than six years, showed that they struggled with

living within two cultures (Azugbene et al., 2023). One-to-one interviews were conducted, and thematic analysis was used in this study which implied a rich and detailed description of the accounts of participant's views (Braun et al., 2022). The Andersen Healthcare Utilisation (AHU) model was utilised to guide the interview questions which was created from a national survey (Lederle et al., 2021). This model focused on factors that enabled engagement with maternity services, contextual factors such as influences from family and community and individual characteristics factors such as language and length of migration. The use of a validated tool such as the AHU model to create the interview guide is a recommended practice in qualitative interviewing (Turner, 2010). Findings described lack of knowledge, sensitivity and empathy especially regarding FGM from healthcare providers. Women felt they were treated differently or indifferently during their maternity experiences. There was limited examination of the cultural factors that women valued, and the use of the AHU model restricted this. This constraint was particularly evident regarding women's cultural health beliefs and values which warranted further interpretation. The need for culturally competent models of healthcare to address individual and environment factors for migrant Black African women during pregnancy was recommended by Azugbene et al. (2023). This was not a homogenous group of women which could impact on transferability to other Black African populations due to differences in the cultural context of women (Polit & Beck, 2020). However, the recommendations complemented those suggested by Hill et al. (2012) regarding increasing cultural knowledge of healthcare providers. Hill et al. (2012) suggested Somali specific workshops for healthcare providers, whilst Azugbene et al., stated that health workers required training on the cultural norms of African immigrant women.

Similar recommendations to Azugbene et al. (2023), were proposed in a phenomenological study conducted by Murray et al. (2010), who explored the birth experiences of ten African women, who had spent less than five years in Australia. The limitations of Murray et al's (2010) study is that it was unclear which countries the African women were from as this would have provided more scope to understand the cultural factors relevant to women. However, it was stated that the participants were a heterogenous group of African women who were diverse in terms of language, age, nationality, and religion. In addition, the data analysis approach was unclear, meaning that issues of dependability of the study findings could not be determined (Ahmed, 2024). Murray et al's (2010) study involved the input of bilingual educators in the formation of the research questions and they were also present during the interviews and provided feedback for data collection. This raises the question of bias and how this was managed within the research process which negatively impacted on confirmability (Connelly, 2016), but could also strengthen credibility due to

investigator triangulation (Polit & Beck, 2020). Migrant women reported feeling alone and different and revealed that there was lack of cultural understanding from health providers. Although, there were negative experiences reported by Murray et al. (2010), there were positive reports from women of the care provided by midwives and provision to share their cultural beliefs, but this was dependent on the cultural competence of the care provider and time made available during consultations. Concurring with studies from Azugbene et al. (2023) and Wojnar (2015), being treated differently due to their culture was a view held by women, leading to a sense of powerlessness. Murray et al. (2010) recognised the gaps in the literature regarding the factors that encourage or discourage migrant Black African women's participation in maternity care. Cross cultural training for healthcare professionals was recommended but this was more related to highlighting refugees' experiences and management of FGM (Murray et al., 2010).

Pregnancy seen as a normal life event

Two qualitative Australian studies with migrant Black African women reported pregnancy being regarded as a normal life event. Carolan and Cassar (2010) conducted a qualitative study which involved interviews with 18 recently arrived pregnant African women in Australia. The study explored the antenatal care perceptions of women, who were mostly from the Horn of Africa and Sudan who had been in Australia between three weeks to two years. Responses were elicited about women's likes and dislikes about pregnancy care, if they had any concerns and what could be done to improve their experiences. However, only one of the interviews were audio recorded, as consent was not given due to suspicion and cultural concerns. This may have limited accurate documentation of the direct quotes, questioning the reliability of the results. Although, it is argued that not recording is not considered the second-best approach, as written interviews, and audio-recorded transcripts are comparable in the detail captured, and participants are willing to share more information when not being recorded (Nordstrom, 2015; Rutakumwa et al., 2020). Thematic analysis was conducted, and themes showed that women were confused by attention paid to antenatal care and prioritised resettlement. Similar to Hill et al. (2012) and Wojnar (2015), some women did not initially see the value of pregnancy care but begun to assimilate new beliefs and welcomed the health advice available to them when attending for antenatal appointments. Carolan and Cassar (2010) highlighted the importance of cultural sensitivity and understanding of the traditional view of pregnancy as not being special but a normal process for migrant Black African women. Women's willingness to engage in antenatal care was influenced by the positive and friendly atmosphere of the clinic. Further lines of enquiry into what constituted friendliness or a welcoming environment to the women was required, as this would have been useful to further

decipher any cultural norms. The recommendations from this study were for services that accommodated women's cultural beliefs and practices, and that further research was needed to identify the information needs of women (Carolan & Cassar, 2010). It is argued that some aspects of maternity care in Australia is comparable to the UK, and therefore, the recommendations were valid in both contexts (Blair et al., 2024).

Mohale et al. (2017) explored the experiences of 14 Sub-Saharan women who had given birth in both Africa and Australia. The uniqueness of this qualitative study was the comparison of birth in Africa and Australia, and consideration of the impact of acculturation (Sam & Berry, 2010). It should be noted that women came from just six African countries, mainly Sudan and did not include West African countries. This omission was a limitation as there has been criticism that there is a dearth of Australian studies that research wider African populations making transferability dangerous (Fozdar, 2023). Empowerment due to respectful care and disempowerment due to poor communication were experienced by women. Perceptions of needs and desire for care were influenced by women's belief that pregnancy was normal. Women revealed that they did not have sufficient knowledge and had minimal health literacy to identify problems during pregnancy. The women who had subsequent pregnancies in Australia after giving birth in Africa recognised the benefits of professional care. Similar, to care in Africa, women reported long waiting times but were impressed with the level of care they received which they could not afford in Africa. The stark differences in birth in Africa compared to Australia was highlighted in Carolan and Cassar's (2010) study. Although, the healthcare services were more easily available in Australia than in Africa, due to free access, women complained that antenatal classes were portrayed as optional, information was offered in written form with no verbal discussion and healthcare providers spoke to quickly and used unfamiliar words. Preference for health information to be offered verbally was also reported by Hill et al. (2012). Mohale et al's (2017) findings that migrant women's maternity needs were shaped by socio-cultural norms were echoed by Carolan and Cassar (2010). The length of time in Australia was between 1-11 years, showing that these issues did not just impact on new migrants. Mohale et al. (2017) proposed the importance of cultural sensitivity and the need to acquire cultural knowledge when providing care for Black African women, particularly new migrants. This was similar to recommendations from Azugbene et al. (2023), Carolan and Cassar (2010), Dike (2019) and Hill et al. (2012). Furthermore, it was recommended that improving health literacy would empower women to determine their own health needs and promote timely access to healthcare (Mohale et al., 2017).

Cultural expectations and challenges

Four studies reported women's expectations of maternity services not being met and challenges of engaging with healthcare professionals. Strauss et al. (2009) adopted a qualitative ethnographic approach in their study which involved interviews with eight Somali health professionals who had given birth in the UK. The women were asked to discuss their experiences of childbirth and provide some insight as a healthcare professional. The women's occupations ranged from health advocates, interpreters and community and health workers. It was noted that none of the women were registered healthcare professionals in the UK, and only four were health professionals prior to migrating to the UK. Therefore, their clinical experiences were limited to non-UK healthcare provider experience. Thematic analysis revealed that cultural expectations of care, such as seeing one midwife antenatally were expected by the women, who found it difficult to develop relationships with so many healthcare providers. There were challenges with utilising maternity services as women felt they were judged and stereotyped by healthcare professionals as being unintelligent and that they lacked knowledge about childbirth and family planning. Communication challenges were a key finding, particularly as women were averse to receiving written information as the Somali have an oral culture, it was preferred that information was shared orally, as found by Hill et al. (2012) and Mohale et al. (2017). The ethnographic approach with no definite research question used in this study was useful in revealing rich narratives of women's experiences (Hammersley & Atkinson, 2019). Strauss et al's (2009) study had similar recommendations to studies in the USA with Somali women (Hill et al. 2012; Wojnar, 2015), proposing the need for further information on women's migration experiences to support their expectations of maternity care.

A qualitative exploratory study with 70 Somali women in Finland found that their perceptions were important for health professionals to achieve culturally competent antenatal care (Degni et al., 2014). Most of the women, (92%) had lived in Finland for less than ten years, therefore they were able to share their experiences of being a migrant. The researchers stated that they used concepts of cultural care to guide the data analysis. However, the specific approach was not stated, impacting on confirmability of the study findings as lack of information on the process of the data analysis potentially meant that the results could not be confirmed by others (Polit & Beck, 2020). Women revealed during focus groups, cultural challenges and unfriendly attitudes from doctors and midwives. In contrast, women also reported good experiences of reproductive healthcare despite the cultural differences and valued the availability of high-quality maternity services. Three of the focus groups had a large number of participants (15, 17 and 20) which may have affected

the dynamics of the group and limited any discussions (Gammie et al., 2017). It would have been beneficial for some women to have a one-to-one interview, to gain a deeper understanding of their experiences around the cultural challenges, as several examples were given around FGM and communication which required further explanation. Degni et al's (2014) findings were similar to Azugbene et al's (2023) study with a heterogenous group of Black African women and Hill et al's (2012) study with Somali women in the USA, regarding communication issues and lack of cultural knowledge of health providers.

Tobin et al's (2014) qualitative study conducted in Ireland, used a structured approach to narrative enquiry to gain insight into 22 women's expectation of childbirth, whilst seeking asylum. Inadequate, poorly organised maternity services and lack of staff training in cultural competency were reported by Tobin et al. (2014). Nigerian women constituted a large part of this sample (n=14). A strength of this study was participant involvement in the study design which would have added valuable insight from their experiences and reveal any barriers or facilitators to their compliance (Hatch et al., 2024). Validity was strengthened by member checking as participants could confirm if the research findings accurately reflected their responses (McKim, 2023). A pentad narrative analysis was used in this study which seeks to reveal the relationship between language, thought and action, differing from thematic analysis by reviewing the differences in cases and describing the dynamics of individual narratives (Floersch et al., 2010). Therefore, the motivation and reasoning behind women's perceptions were easier to explore lending more depth to the findings. Tobin et al. (2014) acknowledged that asylum seekers face different barriers to accessing care compared to women who have migrated for other reasons. Women's antenatal experiences showed imbalances between women's expectations and care provided by healthcare professionals leading to feelings of fear and isolation, mirroring Dike's (2019) findings with Nigerian women in the UK. However, unlike Dike's study where the Nigerian women spoke English, communication became an issue when there was no availability of interpretation services. Recommendations were for further research to look at antenatal care and childbirth education needs of ethnic minority women and mandatory training in cultural competency. The recommendations for further training on improving health professionals' perceptions when caring for migrant women in Tobin et al's study reverberated conclusions from other studies with migrant Black African women in America, Europe, the USA, and Australia (Azugbene et al., 2023; Degni et al., 2014; Hill et al. 2012; Murray et al., 2010).

Unlike other studies, Sarantaki et al. (2020) aimed to examine the perinatal cultural practices of African refugees in Greece with the specific goal of enhancing cultural awareness and sensitivity of healthcare providers. This was a large cross-sectional study involving 42 refugee African women (Congo, Ghana, and Cameroon). Questionnaires were answered by women who were assisted by interpreters, the rationale for this method was not provided and the data analysis process was not discussed. The questionnaires were used as an interview guide. The findings provided specific cultural aspects of expectations of antenatal care, birth support, diet, and postnatal practices. The findings from this study like Dike's (2019) study with Nigerian women and Hill et al's (2012) study with Somali women, further contributed to the cultural knowledge available on Black African women particularly as the sample was heterogenous. Sarantaki et al. (2020), had similar recommendations of culturally orientated training for midwives which were also proposed by Azugbene et al. (2023) and Hill et al. (2012). In addition, the importance of providing care through a cultural lens, increasing cultural insight, and including family members in decision making was stated to be necessary when caring for migrant women (Sarantaki et al., 2020).

Language difficulties

Two studies reported language difficulties as being a barrier to maternity care for migrant Black African women. A case study conducted in the UK consisting of semi structured interviews with six Somali women and two focus groups reported racism and language barriers (Bulman & McCourt, 2002). This study included interviews with healthcare professionals and was part of a wider study that investigated a new model of caseload midwifery, exploring if women's perspectives were considered during implementation. All interviews were conducted with a Somali interpreter utilising a narrative approach, which would have allowed the participants to fully discuss their experiences (Anderson & Kirkpatrick, 2016). The data was coded, and themes generated, and the research participants were invited to feedback on the results in a discussion group which strengthened credibility of the findings (Connelly, 2016). Findings from the women's narratives, reflected those found in studies in the USA, Australia and mainland Europe pertaining to language barriers and lack of cultural sensitivity (Azugbene et al., 2023; Hill et al. 2012; Mohale et al., 2017). However, the data analysis approach was unclear, so this should be considered when reviewing the findings. The recommendations from Bulman and McCourt (2002) were for more explicit education for healthcare professionals who work in a multicultural society. Bulman and McCourt's (2002) early study demonstrated that issues such as racism and cultural factors in maternity care has been an ongoing issue for decades despite the available evidence on how to improve migrant women's experiences.

Language difficulties and cultural unfamiliarity were found in a qualitative study conducted with 16 Somali women in Leicester (UK) by Konje and Konje (2021) who conducted focus groups, and five one-to-one interviews underpinned by grounded theory methodology. The focus of this study was women's access to maternity care, unlike Bulman and McCourt (2002) and Strauss et al. (2009) who focused on Somali women's experiences of receiving maternity care. The study included women who had recently accessed maternity services or had a baby within the last two years, time in UK ranged from five to eleven years. Therefore, consideration of impact of acculturation on health seeking behaviour may have been evident (Sam & Berry, 2010). The data collected was analysed using constant comparison which is appropriate for grounded theory (Birks et al., 2019) and facilitated a deeper exploration of women's views. Women reported on aspects of antenatal care provision mentioning communication difficulties, lack of empathy and support and insufficient understanding of their culture, even without language barriers. The views of the women who had lived in other European countries could have reduced the validity of the results due to acculturation (Sam & Berry, 2010). However, Konje and Konje (2021) justified that the experiences of migrant women in any European country would be similar. Recommendations for appropriate language support and effective communication, staff training on cultural sensitivity and education of health professionals around cultural practices were comparable to other studies (Azugbene et al., 2023; Degni et al., 2014; Hill et al., 2012; Murray et al., 2010).

2.8 Health care providers' views of providing care for migrant Black African women

The themes that were derived from the studies that explored the views of healthcare professionals who had cared for migrant Black African women during pregnancy were: Lack of cultural knowledge, Migrant women expected to adapt to dominant culture and Service constraints.

Lack of Cultural knowledge

There were two studies that explored health care provider's experiences of working with ethnic minority women, showing that their cultural knowledge deficiencies impacted on the quality of antenatal care provision. Goberna Tricas et al. (2005), conducted a descriptive observational study utilising a self-completed questionnaire for data collection in Spain. Questionnaires are stated to only be effective if they measure what they are meant to measure and may not apply to diverse cultural environments (Boynton, 2004), so the findings from Goberna Tricas et al. should be

considered in light of this. There was no discussion of using a validated questionnaire which raised the issue of trustworthiness (Adler, 2022) however, a pilot study was conducted, and a brief overview of the questions was provided increasing confidence in the data collection tool (Malmqvist et al., 2019). The questionnaire response rate was 44% (total=147), with only 19 of the midwives having cared for an average of five to seventeen Senegalese and Gambian women in the last year. The study did not provide detail on how the questionnaire was distributed, however a response rate of between 15-77% is argued to be adequate for a sample of 150-155 participants (Nulty, 2008). Hence, the results of this study could be a valid reflection of the midwives reviewed but caution should be taken when reviewing the findings due to the response rate. Results were analysed using a SPSS_PC 11 statistical programme and a descriptive study of the variables was carried out. Findings showed that midwives desired training on African cultures and customs. Goberna Tricas et al. (2005) proposed the development of cultural mediators in midwifery practice and student midwife training and continuous professional development on culture and diversity. The cultural knowledge recommendations for maternity healthcare providers were reflected in other studies (Degni et al., 2014, Hill et al., 2012; Murray et al., 2010).

Goberna Tricas et al's (2005) findings of lack of cultural knowledge was reported by Degni et al. (2014), in a study that explored healthcare provider's experiences of reproductive health for Somali women in Finland, with a focus on transcultural awareness. A qualitative descriptive approach was the stated methodology for this study. This approach allows researchers to stay close to the data and the surface of words and events (Sandelowski, 2000). Four interviews and two focus groups were conducted with ten gynaecologists/obstetricians and one focus group with eight nurses/seven midwives. The size of 15 in one focus group is considered large and may have limited a deep discussion of the issues (Guest et al., 2017). In addition, one focus group lasted 30 minutes which is less than the usual time of 60-90 minutes for adequate data collection meaning there may have been limited exploration of crucial information (Cronin, 2008; Krueger, 2014). Content analysis was utilised to create the codes and themes, and the research results were presented as illustrative quotes which is recommended to increase authenticity of the results (Hsieh & Shannon, 2005; Kleinheksel et al., 2020). It was unclear if the interviews or focus groups occurred first however, findings from the focus groups were compared to the interviews and categorised together providing a unified picture of the healthcare professionals. However, it would have been useful to see how the findings from the doctors differed from midwives. Specific training for healthcare professionals on how to interact with women from diverse cultural and religious backgrounds was recommended (Goberna Tricas et al., 2005).

Migrant women expected to adapt to dominant culture

A study conducted in Ireland with healthcare professionals, sought to understand how services coped with increased migrant populations and found that there were cultural differences and an expectation that ethnic minority women were expected to adapt to a new healthcare system (Lyons et al., 2008). This expectation demonstrated that health services failed to acknowledge the individual needs of migrant women, especially during the crucial time of pregnancy. Five focus groups (n=5-7 per group) were conducted with midwives and one auxiliary nurse, and semi structured interviews were undertaken with 15 obstetricians and key informants from infection control, social services, and bereavement services. Lyons et al. (2008) used a grounded theory approach and data was coded into themes however, the exact analytical approach was not discussed. Dependability was strengthened as three people coded the data, thus reducing bias (Connelly, 2016). It was stated that data collection ceased after saturation was achieved but no further detail was provided on this aspect. It was reported that 42% of the ethnic minority population in Ireland were from Africa, however, healthcare professionals viewed all ethnic minority women as Africans (Lyons at al. 2008). This demonstrated lack of cultural awareness, which is a starting point to exploring and recognising differences and seeing the woman as a unique individual (Papadopoulos, 2006). Healthcare professionals reported that they viewed migrant women as a homogenous group which was similar to other studies. Views of all Nigerian women being seen as having a positive demeanour and being able to adapt were reported by Dike (2019), in a study with London midwives. Tobin and Lawless-Murphy (2014) found the same beliefs of African women being viewed as homogenous with Irish midwives. This showed the similarities in health care professional's perceptions of migrant women in different contexts. Lyons et al. (2008) reported communication difficulties when providing care, women having limited knowledge of maternity services and cultural differences. However, it was unclear which were the views of midwives and other healthcare professionals, therefore impacting on transferability to other settings (Adler, 2022). A multicultural approach in maternity services was a recommendation from Lyons et al. (2008), similar to proposals from Azugbene et al's (2023) study in the USA and Carolan and Cassar's (2010) Australian study with Black African migrants.

Service constraints

Three studies revealed service constraints leading to midwives being unable to provide appropriate care for Black women. The views of 20 British midwives were sought by Aquino et al. (2015) with a

focus on exploring pregnancy interventions for BME women. This was a qualitative study but the rationale for the methodology and thematic analysis was not provided impacting on dependability of the research which would be difficult to replicate due to lack of detail in the process (Ahmed, 2024). Semi structured one-to-one interviews with midwives were undertaken in one NHS Trust in Manchester where one third of the population in the Trust catchment area was from a BME background. Midwives had a median of 14 years working in a range of clinical midwifery settings. Two researchers conducted coding, however none of the researchers were midwives and had never been pregnant, but two were from BME backgrounds. This could be seen as a limitation due to potential coding disagreements and lack of midwifery clinical experience and also a strength due to shared ethnicity with research participants. Coding conflict could have been counteracted by the use of a codebook to guide the process (Hemmler et al., 2022), however this was not utilised in the study. It was not identified that the BME population were African migrants apart from the term 'new to the UK' being referred to in the paper. A breakdown of the migrant population would have been useful due to potential cultural differences. Findings included language barriers, expectations of maternity care and complex needs beyond pregnancy and organisational limitations in providing care for women which was not within the remit of the midwife. Midwives expressed a strong sense of commitment to advocating for women despite these issues. Further research on NHS maternity services was recommended to explore perceptions of BME service users and training for midwives on cultural and religious practices.

Service constraints resulting in midwives feeling powerlessness and unable to provide effective care was revealed by Tobin and Murphy- Lawless (2014), who conducted a study exploring Irish midwives' experiences of caring for non-Irish asylum speaking women. This was a qualitative study using in-depth unstructured interviews and content analysis. Ten midwives participated, who worked in a larger inner-city hospital (n=5) and a smaller rural hospital (n=5) with a range of clinical experience (1-15 years), nine of the midwives were Irish. The midwives had cared for women from six different African countries (Nigeria, Cameroon, Burundi, South Africa, Sierra Leone, and Zimbabwe); and therefore, would have been exposed to diverse cultures. Asylum seekers are known to face a range of challenges throughout the asylum process, with experiences of persecution and trauma (Hoare et al., 2024; Trueba et al., 2023). The lack of services described by midwives were limited psychiatric care or counselling, inadequate interpretation services, and insufficient parent education facilities, but to what degree this impacted on care provided warranted further investigation. It was reported that midwives were unprepared and unequipped to care for traumatised women, however, they developed empathy and compassion when hearing their

stories (Tobin & Murphy-Lawless, 2014). Factors that facilitated staff well-being could have been explored further in this study, as midwives' ability to provide culturally competent care were impacted by women's stories. Training for midwives on cultural humility which focused on self-awareness and effective communication and were attentive to women's beliefs, and goals was recommended (Tobin & Murphy-Lawless, 2014). In addition, clinical support was advised for midwives who care for traumatised women. However, provision of adequate ancillary services was not proposed in this study, which would have been appropriate given the discussions on dealing with women's traumatic events.

Oscarsson and Stevenson-Agren (2018) conducted five focus groups (n=3-4) and a single interview with Swedish midwives. The purpose of this qualitative study was to explore midwives' experiences of providing antenatal care to immigrant women. At the time of the study, it was reported that 36.7% of women in Sweden were migrants with 5% of this population from Africa, particularly Somalia. Content analysis was used to examine the data, Oscarsson and Stevenson-Agren (2018), explicitly discussed the cultural clashes between midwives and women who had different expectations of antenatal care which were unable to be accommodated. This conflict was echoed in other studies with migrant African women (Degni et al., 2014; Dike, 2019: Sarantaki et al., 2020). Revealing an international commonality of cultural conflict between healthcare professionals and migrant women. Oscarsson and Stevenson- Agren's (2018) findings of inadequate services that did not address the needs of migrant women were mirrored in the UK by Aquino et al. (2015) and in Ireland by Tobin and Murphy-Lawless (2014). The educational status and previous pregnancy experience of women assisted in overcoming communication barriers, showing that women who were illiterate or had less pregnancy experience were more likely to have challenges in understanding relevance of care provided (Oscarsson & Stevenson- Agren, 2018). Midwives utilised alternative solutions to overcome communication issues, even when using interpreters and developed the skill of performing cultural assessments of women and to use verbal and non-verbal communication. It was recommended that midwives needed time and support to manage cultural differences and manage women's expectations of maternity care services. It was also proposed that further research was needed to develop new communication tools and different ways of communicating with immigrant women (Oscarsson & Stevenson- Agren, 2018).

2.9 Grey literature

The grey literature was searched in light of the high profile of Black maternal deaths in the UK reported in the news and on social media. Information on public health interventions, as well as evaluations of health interventions may be found in grey literature (Adams et al., 2016). Five studies/ reports were identified that had some focus on Black African women's maternity experiences, two doctoral studies, a survey study, and two reports. A House of Commons report on Black maternal health highlighted the need for culturally competent care and addressed the lack of research on Black women in the UK (Women and Equalities Committee, 2023). There were no doctoral studies that specifically explored Black African women's or midwives' perceptions of cultural competency in antenatal care. However, two studies were found that considered perspectives of ethnic minority women and motherhood. Hassan (2017) conducted a doctoral study on the experiences of British Muslim women of motherhood and healthcare professionals' experiences of caring for Muslim women. A generic qualitative approach and thematic analysis was utilised in this study. Although, the focus of this study was religious practices during and after pregnancy, there were women included who were Black Africans (n=9), length of time in the UK ranged from nine years to 25 years. Longitudinal interviews were conducted with eight first time mothers, one of which was a Black African, this approach was useful in exploring the woman's pregnancy journey. Each woman was interviewed three times between 29 and 40 weeks of pregnancy, two months after birth and, four to six months later. Hassan (2017) recommended the development of training programmes that increased the knowledge and understanding of religion, culture, and ethnicity for healthcare professionals. There was acknowledgment of the NHS requirements to meet the needs of a diverse population.

A doctoral study conducted in the USA, explored Sub-Saharan African refugee mothers' perceptions of maternity care and health providers' experiences of caring for refugee women during pregnancy (Ward, 2019). This study was conducted in three phases. The first phase was a systematic review of Sub-Saharan refugee women's maternal health needs and their perceptions of healthcare services. The second phase was a case study of the experiences of two refugee mothers during pregnancy care and the third phase was a qualitative study conducting interviews with health providers. The findings from the literature review showed that there were language differences even with interpreters, that women wanted equal treatment and respect for their culture, however women reported positive experiences and support from health providers (Ward, 2019). Recommendations from Ward's review advised that clinicians must become culturally fluent and understand cultural values and norms of Sub-Saharan women. Thematic analysis was used for data analysis for the

case studies and interviews. Cultural capital, familiarity with dominant culture including language, education and qualifications was revealed as being a determining factor of how migrant women resettled in the USA. Ward (2019) found that health professionals wanted to know more about the culture and childbirth practices of migrant Sub-Saharan women and desired diversity and inclusion training.

The Fivexmore charity conducted a survey in 2022, on the maternity experiences of Black mothers in the UK (Fivexmore.org, 2024). This study was an experiential analysis of the antenatal, intrapartum, and postnatal lived experiences of Black women residing in the UK, who had accessed NHS maternity services between 2016 and 2021. An online survey of a maximum of 92 questions was completed by 1340 women, 45 % of the mothers were Black African and 26% were not born in the UK. The survey was disseminated across a vast range of social media platforms, including Twitter, Instagram, and WhatsApp. The quantitative data was reviewed using inferential analysis and qualitative data was reviewed utilising a thematic content analytic approach. Recommendations were for more research on Black women to dispels stereotypes and prejudice and more education for healthcare professionals to eradicate racial assumptions about Black women. Potential limitations were that the research team were of Black heritage leading to potential implicit bias. This was a large-scale study which added to the limited knowledge of Black women's perinatal experiences. However, most of the issues women raised related to the intrapartum and postnatal period but these were still pertinent to antenatal care. Birthrights, a UK charity advocating for women's human rights in childbirth, published a report in 2022, titled 'Systematic Racism, Not Broken Bodies', derived from intensive inquiry involving 300 participants through online submissions and 11 focus groups with diverse communities (Birthrights, 2022). This report revealed the urgent need for robust anti-racism training and culturally sensitive care in maternity services.

2.10 Identification of gaps in the evidence

This literature review highlights the lack of research exploring the perceptions of cultural competency in antenatal care amongst migrant Black African women and midwives. In the UK, maternal mortality rates for Black women are almost four times more compared to White women (Knight et al., 2023). Inadequate utilisation of routine antenatal care by Black women increases their risk of maternal death. Several maternal mortality reports state that poor antenatal care attendance by Black women, particularly recent migrants may be connected to cultural factors. Although, many studies have

examined the experiences of migrant Black African women during maternity care, there is a lack of research on their perceptions of cultural competency in antenatal care. Furthermore, midwives' perceptions of cultural competency in routine antenatal care provision are mainly absent from the literature. This research gap limits our understanding of how maternity services providers can optimise migrant Black African women's experiences and cater for their cultural needs.

Studies showed that cultural awareness and sensitivity is necessary in the provision of antenatal care. This literature review assisted in refining the focus required for this PhD study and in particular the methodology adopted. The grey literature reconfirmed findings from international and national studies that there are cultural issues that impact on good quality care for Black African women in the UK. Overall, the general recommendations derived from this literature review was the need for cultural competency training for health care professionals (Aquino et al., 2015; Degni et al., 2014; Fair et al., 2020; Tobin et al., 2014). Only three studies added to the evidence on cultural knowledge in pregnancy for migrant Black African women (Dike, 2019; Hill et al., 2012; Sarantaki et al., 2020). The dearth of information from migrant Black African women with lived experience on the cultural needs that are relevant during pregnancy demonstrated the need for further research in this area.

2.11 The research question

This literature review demonstrates the need for further research on childbirth educational needs of migrant Black African women, exploration on how to tailor care to their cultural needs and preferences, culturally appropriate models of midwifery care, and how to increase the participation of Black women in research (Carolan & Cassar, 2010; De Freitas et al., 2020; Women and Equalities Committee, 2023). Studies have revealed the need for maternity care providers to be equipped to care for migrant Black African women during pregnancy. Various recommendations have included cultural competency training, information on how to interact with women from different cultures, knowledge of diversity during midwifery education, education in cultural awareness and cross-cultural training (Aquino et al., 2015; Degni et al., 2012; Higginbottom et al., 2019; Konje & Konje, 2021; Murray et al., 2010; Shorey et al., 2021; Tobin & Murphy-Lawless, 2014). Educational programmes designed to improve cultural awareness, sensitivity and knowledge of midwives requires essential information to ensure effective content and delivery. Existing literature offers little support on migrant Black African women's or midwives' perceived understanding of cultural competency. Consequently, there is limited information that can inform what cultural competency

looks like in antenatal care provision. Information on the differences in the perceptions of migrant Black African women and midwives of the phenomenon of culturally competent care is vital. There is a potential that these differences can be addressed so that migrant women's expectations of antenatal care are met. In addition, further research has been recommended on the perspectives of the care giver and enquiry into healthcare provider' beliefs and expectations and how these can be addressed by cultural competency (Aquino et al., 2015; De Freitas et al., 2020). There were no studies that focused exclusively on the antenatal experiences of migrant Black African women or midwives' experiences of providing antenatal care to migrant mothers which demonstrated a gap in this timeline of pregnancy which is a crucial element for reducing poorer pregnancy outcomes. Hence, the research questions are '*How do the perceptions of migrant Nigerian women differ from midwives' perceptions of cultural competency in antenatal care?'* and '*What are the cultural needs of migrant Nigerian women and how are their needs currently addressed within antenatal care provision in the NHS?'*, to capture the perspectives of migrant Black African women and midwives. Given the constraints of this doctoral investigation, a cohort comprising solely of Nigerian women was chosen. This selection was motivated by the recognition of Nigerian women residing in the UK as a demographic historically associated with heightened mortality risk since 2000 (Knight et al., 2023). A qualitative approach was employed to examine the firsthand experiences of women and midwives, similar to other studies. Content analysis was utilised to remain closer to the data and unlike thematic analysis assisted in revealing the voices and views of the research participants rather than the views of the researcher.

2.12 Summary of chapter

This chapter represents a rigorous critique of existing literature pertaining to the pregnancy experiences of migrant Black African women and the professional experiences of healthcare providers. Published primary studies, systematic and narrative reviews and studies identified from the grey literature have been included in this critique. The dominant themes from these studies have been acknowledged, revealing that migrant Black African women have reported cultural insensitivity and lack of cultural awareness and knowledge in maternity care provision and midwives struggle to care effectively for migrant mothers. The research questions sought to reveal migrant Nigerian mothers' and midwives' perceptions of cultural competency in antenatal care. Extant research has mainly focused on the maternity care experiences of migrant Black African women and healthcare providers experiences in providing pregnancy care to these women. While it is shown that a relationship exists between inadequate antenatal care utilisation and pregnancy outcomes, it has not been robustly shown how cultural factors affect this. There is limited evidence on the cultural

needs of migrant Black African women during pregnancy and there is a paucity of studies that explore midwives' cultural knowledge and perceptions of cultural competency. Furthermore, the lack of studies focusing on antenatal care provision is evident despite reports that link recent migration, poor antenatal attendance, and engagement, with adverse maternal and fetal outcomes (Knight et al., 2023). Accordingly, this comprehensive review provides a robust foundation for the research questions underpinning this study. The ensuing chapter will present the methodology adopted for this PhD study and the methods used to answer the research questions.

Chapter 3: Methodology

Introduction

This thesis was undertaken to explore migrant Nigerian mothers' and midwives' perceptions of cultural competency in antenatal care, to investigate factors that influence antenatal care attendance which may impact on maternal mortality rates. A review of research methodologies was conducted to determine the most appropriate methods to answer the research questions. My philosophical stance is explained, and a rationale is provided for the chosen research methods. This study had a two phased research design which is described in this chapter. The issues and ethical dilemmas that arose from conducting this study are discussed.

3.1 The research questions

The research questions are, 'How do the perceptions of migrant Nigerian women differ from midwives' perceptions of cultural competency in antenatal care' and 'What are the cultural needs of migrant Nigerian women and how are their needs currently addressed within antenatal care provision in the NHS? These questions were formed from the literature review which demonstrated that there were specific elements of inquiry into maternal mortality that required further exploration regarding migrant women's utilisation of antenatal care. The gaps in the evidence revealed that further information was required on migrant Black African women's and midwives' perceptions of cultural competency in antenatal care. Therefore, the methodology adopted for this study required an approach that could answer the research questions.

3.2 Qualitative research

An inductive approach was required in this study, whereby the generation of new theory is desired. A qualitative approach was essential to make sense of or interpret people's meaning of the phenomenon (Denzin & Lincoln, 2018; Moser & Korstjens, 2018). In essence, qualitative research involves asking open ended questions and therefore, answers cannot be easily quantified (Cleland, 2017). Although quantifying qualitative data is feasible, frequently analysing qualitative data involves looking for themes and patterns with consideration of context (Tenny et al., 2022). The inductive approach used in qualitative research allows the findings to emerge from the data without restraint (Azungah, 2018; Thomas, 2003). Collection of numerical data or utilising interventions to test a

hypothesis does not occur in qualitative data (Adler, 2022), as the process involves gathering of participant's experiences and perceptions or observation of behaviour (Tenny et al., 2022).

Although concerns have been raised about the lack of objectivity and generalisability in qualitative research (Sandelowski, 1993), the rise of evidenced based practice as a methodology for healthcare has increased the usefulness of qualitative research (Cypress, 2015). The ability for qualitative research to answer 'what' and ' how' questions which can provide insights into aspects of behaviour and perceptions is a key strength (Teti et al., 2020). In particular, the subjective view of participants is difficult to explore without a qualitative approach. This strengthened my selection of a qualitative approach for this PhD study, as an understanding of participant's views was necessary. Qualitative research allowed me to hear the participant's voices through interviews and focus groups allowing in-depth conversations that provided a more detailed response. Therefore, this approach was the best possible fit for this PhD study.

3.3 Ontological and epistemological view

It is argued that all researchers have a personal view on what is knowledge and what is truth (Chilisa et al., 2012). These personal views influence the way researchers perceive themselves and other individuals as well as their views of the world (Kamal, 2019). Guba and Lincoln (1989), state that ontology, epistemology, and methodology are intrinsically linked to a research paradigm. Ontology relates to the central question of whether individuals need to be seen as objective or subjective beings (Blaikie & Priest, 2019). Furthermore, ontology is concerned with the nature of existence and how we know about the world (Crotty, 1998). My personal view of what is reality and what constitutes knowledge was considered when deciding the design of this study. As a midwife who had spent many years relying on the views and perspectives of women to guide their care, I naturally veered towards subjectivity as being crucial in a research study. However, I also believed that subjectivity could be impacted by external factors. Awareness that there could be misinterpretation of an individual's thoughts when seeking their views was at the forefront of my concerns, as it may be difficult to explain the essence of what research participants were saying. However, Rees et al. (2016) states that the goal is not to achieve an accurate or impartial representation but to value subjectivity. Epistemology is the assumptions we make about the nature of knowledge and how it is possible to find out about the world (Al-Saadi, 2014). The framing of a research question inadvertently reflects a commitment to a particular model of how the world works (Silverman, 2013). There are three main epistemological positions, objectivism which states there is an objective reality

independent of the subject, subjectivism where the subject creates meaning and imposes this on the objects and the third position is constructivism. The constructivist paradigm states that realities are multiple and only exists in the minds of the people who experience this reality (Bunniss and Kelly, 2010; Guba & Lincoln, 1989; Kumar, 2008). My epistemological stance was constructivism, as I believed that knowledge was constructed by individuals from their lived experiences.

The methodology that aligns with a researcher's epistemological and ontological view is favoured when conducting a research study. Methodology is defined as a bridge between theory and methods, offering consistency throughout the research process (Kramer-Kile, 2012). The concepts and theories that underpin the methods adopted should be discussed in any research study. The term research paradigm is perceived as a way of seeing the world that frames a research topic, therefore, influencing the way I would investigate a problem (Guba, 1990; Kamal, 2019). It is stated by Mason (2002), that my choice of methodology is likely to reflect my biography, knowledge, training and education and it is suggested that a process of making a list of possible research methods and deciding which should be accepted or rejected is required. The research questions I devised for this study aimed to discover individual's subjective experiences of their world in a specific context which supported my ontological view that reality is subjective and an epistemological view that the generation of this knowledge can only be through interaction and exploration of an individual's accounts (Bryman, 2016). My position as a Black researcher is stated to have an influence on the framing of the research question and priorities are ranked differently (Smith, 2021). My priorities within this study were to recognise the impact of the colonial past, be accountable to the research participants and not to subscribe to a research methodology that distanced me from this standpoint. I examined quantitative and qualitative research methods to determine the best approach for this PHD study. In this way I did not disregard research approaches at face value due to my biases or any preconceived beliefs. The importance of this study to the Black women and the midwives that I researched were key considerations in the selection of the most appropriate research approach.

A quantitative approach was not suitable to answer the research questions of 'what' and 'how' as I required a thorough investigation into the underlying meaning of women's and midwives' views. Quantitative research starts with a statement of a problem which is used to generate a hypothesis and employs strategies such as surveys and experiments to collect data using predetermined instruments (Apuke, 2017; Creswell, 2014). I had no hypothesis at the start of this study and in quantitative research a deductive approach is adopted that seeks to draw valid conclusions from a

hypothesis, hence there is a premise that requires testing (Kandel, 2020). Moreover, quantitative research tests objective theories by investigating the relationship between variables (Taherdoost, 2022; Lo et al., 2020). The measurement of these variables leads to numbered data, utilising statistical procedures (Kandel, 2020). The inability to quantify women's and midwives' experiences of cultural competency was an obvious limitation to adopting a quantitative approach. Although, the findings generated from quantitative research may reveal trends and patterns, but not the reasons behind any actions or behaviours. Clearly, alternative methods such as interviews and focus groups were needed to explore individual's perceptions or experiences (Goertzen, 2017). I required an in-depth understanding of the phenomenon of cultural competency in antenatal care with no hypothesis assumed, therefore a quantitative approach would fail to develop concepts which illuminated the meaning of the views of the women and midwives.

3.4 Qualitative research approaches

Once I made the decision to adopt a qualitative approach a review of possible methodologies in this genre was undertaken. After I reviewed several qualitative approaches there seemed to be no 'perfect fit' that suited my topic, a problem facing many researchers (Caelli et al., 2003; Ellis & Hart, 2023; Sandelowski, 2000). There was also no standard practice for what decolonising research methodology should look like (Thambinathan & Kinsella, 2021), which as already discussed was of critical importance to me as a Black researcher.

Qualitative descriptive approach

I adopted a qualitative descriptive methodology for this research, a generic qualitative approach that focuses on how people interpret their experiences and construct their worlds in order to provide a rich account of the phenomenon under scrutiny (Ellis & Hart, 2023; Finlay, 2011; Hoon Lim, 2011). Qualitative descriptive studies are comprised of a valuable methodological approach drawing from the general theories of naturalistic inquiry with an obligation to study something in its natural state (Sandelowski, 2000). It is suggested by Neergaard et al. (2009) and Sandelowski (2000) that all research involves interpretation, but qualitative descriptive studies attempts to reduce inferences made in order to remain closer to and describe participants' experiences, which was of upmost importance in this study. Qualitative descriptive studies may have overtones from other qualitative methodologies, such as illuminating lived experiences in phenomenology and generating data in ethnography, but it does not meet the requirements for these approaches (Doyle et al., 2020). There is no priori theory that governs qualitative descriptive research (Bellamy et al., 2016), this approach

is the least encumbered by theoretical or philosophical perspectives (Lambert & Lambert, 2012), therefore, I decided the theoretical perspectives that informed this study. At a minimum Caelli et al. (2003) state that the researcher should identify their disciplinary affiliation, and any assumptions made about the phenomenon. As previously espoused, my views about how knowledge should be interpreted and investigated is echoed within the constructionist paradigm.

A qualitative descriptive approach is appropriate for health care environment research, as in this study, because it provides factual responses to questions about how people feel about a particular space (Colorafi & Evans, 2016; Doyle et al., 2020). Furthermore, a qualitative descriptive approach allowed me to employ methods that obtained a broad insight into the phenomenon (Kahlke, 2018; Neergaard et al., 2009). I acknowledged the subjective perceptions of cultural competency and that participants would have different experiences of this phenomenon (Bradshaw et al., 2017), therefore their diverse views needed to be explored. The existing knowledge on cultural competency required a fuller description from the participant's perspective, which is a strength of a qualitative descriptive approach (Bellamy et al., 2016). Hence, a qualitative descriptive approach fitted my epistemological view, did not impede my attempt to conduct culturally sensitive research and provided the knowledge required to answer this study's research questions.

Narrative Inquiry

I considered a narrative inquiry for this study, which involves capturing the personal and human dimensions of experience over a period and noting the relationship between the individual's experience and their cultural background (Clandinin, 2022; Thomas, 2012). This study aimed to explore the cultural subjective perceptions of Black African women and midwives, which lent itself to the cultural context of narrative inquiry. A narrative approach is similar to the Indigenous research method of storytelling, which is commonly used in non-Western societies as a way of imparting knowledge with limited restrictions (Drawson et al., 2017). However, in PhD studies time is limited (Bell & Waters, 2018) and using storytelling to decipher individual's perceptions of culture, I believed would result in a long and extended process due to the amount of data that would need to be analysed (Creswell, 2014; McCormack, 2004). As a narrative inquiry involves allowing individuals to use storytelling to describe their experiences (Wang & Geale, 2015), I was also concerned that this approach could result in a lack of focus on cultural perceptions.

Ethnography

Ethnography is a methodology that records and analyses a culture usually based on participant observation (Madden, 2022; Reeves et al., 2013). I concurred that ethnography could explain any attitude-behaviour problems and illuminate how individual's perceived antenatal care (Jerolmack & Khan, 2014). However, I envisioned the challenges in attempting to observe an individual's cultural perceptions during antenatal care appointments. Hammersley and Atkinson (2019) state that relying on observation to interpret what people do and think without talking to them risks misinterpretation. In undertaking an ethnographic approach, I would need to have unconstrained observation of individuals who have been together for a period of time specific context (Creswell, 2014, Hammersley & Atkinson, 2019). I would find it problematic to observe participant's behaviour in a series of antenatal appointments probably lasting for fifteen to twenty minutes and avoid being obtrusive. Other aspects of antenatal care such as gauging perceptions of cultural competency during antenatal appointments are also not easily observable actions. All of these factors excluded an ethnographic approach for this study.

Grounded theory

The purpose of grounded theory is to generate theory that is grounded in the data and provide the theoretical explanation of a phenomenon (Corbin & Strauss, 2007). In grounded theory, I was expected to have no preconceived ideas about potential findings which was not the case in this PhD study. I understood that a majority of qualitative studies aim to describe and explore phenomenon, whereas grounded theory seeks to explain the phenomenon (Birks & Mills, 2022). In contrast to other qualitative research methodologies, grounded theory does not identify a research question first and then employ a theoretical or conceptual framework (White & Cooper, 2022), which I had implemented in this study. In grounded theory, the analytical focus emerges during the research process rather than being determined at the onset (Birks et al., 2019; Charmaz & Thornberg, 2021; Turner & Astin, 2021). As I needed to understand mothers' and midwives' perceptions of cultural competency, grounded theory was an inappropriate approach for this study.

Phenomenology

Phenomenology aims to provide an insight into awareness of individual's lived experiences and interpretation of their world (Husserl, 1983; Neubauer et al., 2019). This approach would have been appropriate if I had wanted to study what an experience meant to a group of people (Grossoehme,

2014). The two schools of phenomenology are Husserl's descriptive phenomenology which aims to discover the essence of a phenomenon and Heidegger's interpretive view which has a narrower focus on illuminating the meaning of the experience (Frechette et al., 2020; Polit & Beck, 2020). At first glance, this approach appeared to be a good fit for this PhD study, due to the ability to focus on how individuals perceive an event or phenomenon. However, as phenomenology is the study of the primal lived prereflective meaning of an experience (Van Manen, 2017), this contrasted with this study which aims to explore the perceptions of women and midwives but with a focus on cultural competency. An accurate presentation of the phenomenon is important in phenomenology (Grossoehme, 2014), which posed difficulties in this study as the phenomenon of cultural competency is not easily described due to its many variances. I was interested in the women's and midwives' opinions and experiences rather than their inner experiencing processes which meant that phenomenology was not an appropriate approach for this study (Percy et al., 2015).

Case study research

I explored case study methodology where a case is studied in detail, using any methods that seemed appropriate, the general objective being to develop as full an understanding of the case as possible (Punch, 2013; Schoch, 2020; Yin, 2018). Case study research requires a detailed analysis of a particular event or situation within a defined space and timeframe (Schoch, 2020). It is stated by Stake (2000) that case study is not a methodological choice of what will be studied, supported by Yin (2018) who discusses two essential features for case study research, defining the case and bounding the case. In this study, the case such as a person or group of people, were Nigerian mothers and midwives and the context was antenatal care. However, case study research requires utilising data from various sources and can be time intensive which would be an issue within a PhD timeframe. In addition, case study research was best suited to answer 'why' research questions rather than 'what' which conflicted with the research questions for this PhD study (Nilmanat & Kurniawan, 2021).

3.5 Impact of Covid 19 on data collection

Due to the impact of the Covid 19 pandemic, qualitative researchers needed to transition from face-to-face data collection to other forms such as telephone or internet-based methods (Lobe et al., 2020). I reviewed other methods to determine the best approach for this study taking into consideration social distancing and other factors that could impinge on women's and midwives' participation. Black women may be more willing to contribute to research through methods such as

email or telephone which may be more convenient but also lessen the fear of breach of confidentiality (Fletcher-Brown, 2020). Other electronic methods such as using online platforms may reduce women's fear and may allow more easier access to participation (Zikmund et al., 2014). The use of digital devices and applications may increase willingness to participate if women can do so from home and they can then have access to any relevant information on the research study (Schirmer, 2023). However, feasibility of electronic methods may be encumbered by lack of computer or technology skills for some individuals. My concern was that workload (impacted by the pandemic) meant that health care professionals were unable to engage in research activities and recruitment would be difficult (Archibald et al., 2019). Meeting with participants in places that they usually visit can also assists in data collection (Van der Ven et al., 2022). Therefore, various venues for the data collection were included when applying for ethical approval. I felt confident in undertaking data collection online, as was the case for many individuals, my abilities in use of technology for work purposes increased during the pandemic (Keen et al., 2022).

3.6 Data collection methods

Silverman (2013) suggests that research methods should be chosen based on the specific task at hand and that methods should be 'our servants not our rulers' (p 11). Choosing a data collection method that allowed me to ask pertinent questions was important. Christ (2014) and Punch (2013) supports this view by arguing that questions should take priority over methods. This was the viewpoint during exploration of the options available to obtain the required data. As previously discussed, data collection using observation would have been inappropriate. Difficulty can arise in attempting to understand an individual's mind-set using observation as a data collection method (Metelli & Chaimani, 2020). Observation in research studies can be time consuming and there may be inaccuracies threatening the validity of the research findings (Edmonds & Kennedy, 2016; Siedlecki, 2020). As a researcher, I required some data or information that helped me to understand the context under investigation, as gauging what participants think can be difficult (Fischer & Guzel, 2022). Asking individuals was a simple and direct method when seeking personal views and it was appropriate to ask why something is, rather than observing (Fischer & Guzel, 2022). A questionnaire was deemed to be an inappropriate data collection tool as there is doubt that this method can capture real experiences (Einola & Alvesson, 2021; Hansbrough et al., 2015). I was concerned that answers provided by participants may need further clarification which required a method where explanation of any responses could be explored immediately. Utilising a questionnaire may have resulted in a low response error, where questions are interpreted differently from how the researcher intended, or

response burden where answers could be affected by effort to complete responses (Mes et al., 2019; Molina et al., 2014; Rolstad et al., 2011).

One-to-one interviews

One-to-one interviews with the women participants were used to obtain the appropriate data to address the aims of this research study. Focus groups for data collection were avoided as some Black women could decline participation due to fear or stigma in discussing certain topics (Kruger et al., 2019). Nigerian women living in London may have had links to the same communities and they may have been worried about exposing personal information which they wished to keep private in a focus group setting (Gammie et al., 2017; Prescott et al., 2016; Richard et al., 2021). Focus groups can be conducted in a way that support non-Western ways of knowing by being culturally attuned and ensuring that participants are aware that all knowledge is welcomed (Romm, 2015). Therefore, focus groups could have been an appropriate data collection method in keeping with decolonising research. However, the feasibility of arranging focus groups with new mothers who were new migrants presented challenges, as a time and place to suit all participants would have proved difficult (Cyr, 2016). In addition, involving women in focus groups may have led to not all of their views being heard (Gill et al., 2008), which was a deciding factor in veering away from this method.

The one-to-one interviews with women were conducted face to face or via telephone according to their preferences. Interviews provided in-depth information pertaining to participant's experiences and viewpoints of a particular topic (Turner & Hagstrom-Schmidt, 2022; Turner, 2010). Semi-structured interviews are commonly used in qualitative studies (DeJonckheere & Vaughn, 2019: Kallio et al., 2016; Neergaard et al., 2009). This approach allowed me to investigate a variety of participant's experiences in an attempt to understand the world from their point of view and to unfold the meaning of their lived experiences (Kvale, 2006). I used open-ended interviews whereby participants were asked identical questions, but questions were worded to allow as much detailed information as they desired and the researcher to ask probing questions (Turner, 2010). Interviews were conducted to suit the diversity of individuals, thus moving away from the Western formal asymmetrical approach of interviewer and interviewee, by using informality, flexibility, collaboration, dialogue, and reflexivity (Kovach, 2021). An advantage of using interviews was that the sequencing and wording of the questions could be altered to best fit the interviewee and interview context (de a Croix et al., 2018; DeJonckheere & Vaughn, 2019). An interview schedule was developed as this

strategy can obtain thick rich data utilising a qualitative perspective (Creswell, 2014). The interview method was complex and required the management of the sequence of questions (Evans & Lewis, 2018; Islam & Aldaihani, 2022). The interview schedule allowed me to explore the topic's focus and allowed the interviewees to express their views independently (Choak, 2012; Evans & Lewis, 2018).

Focus groups

Focus groups were the data collection method utilised for the midwives, due to the anticipated ease of bringing midwives together, rather than conducting individual interviews. Morgan (2009) states that a focus group of 90 minutes could generate 70% of the same data generated from eight individual interviews each lasting one hour. Therefore, I felt this approach was justified, as the data retrieved through this process would be adequate. Furthermore, collective views of individuals can be achieved by using focus groups (Gill et al., 2008), which was useful for this study. Researchers have suggested that a sample size of two to three focus groups will likely capture at least 80% of themes on a topic using a relatively homogeneous population and a semi structured interview guide (Guest et al., 2017; Namey et al., 2016). Additionally, dialogue increases when the group is socially and intellectually homogeneous (Lorrain, 2020). In this study, as the focus groups consisted of midwives with the commonality of a shared profession this strengthened the discussions. I recruited two focus groups consisting of six to eight midwives who met the inclusion/exclusion criterion, which is considered an optimum size (Gill & Baille, 2018). A smaller group had the risk of non-attendees and lack of discussion, and participants may have felt exposed and worried about airing their views. A larger group could be chaotic and difficult to moderate, and participants may have felt overwhelmed by shyness or not given a chance to speak if others were more verbal (Gill et al. 2008).

The main objective of the focus groups was to illicit discussions that revealed midwives' opinions about cultural competency. In addition, the focus groups allowed the midwives to hear the ideas of others and remember incidents that they may not have recalled during interviews (Huston & Hobson, 2008). The focus groups permitted midwives to express their views, which was facilitated by not adhering to a strict sequence of questions (Adler et al., 2019; Daniels et al., 2019; Tritter & Landstad, 2020). I acted as the focus group moderator which was useful in answering any questions relating to the research topic (Tausch & Menold, 2016). I held the focus groups through a virtual platform, as whilst face to face focus groups have their advantages, it is often difficult to get everyone together in person, which is something an online platform can overcome (deVilliers et al., 2021; Flynn et al., 2018; Gill & Baillie, 2018). Online data collection methods can reduce richness of data collected, but

by paying attention to group dynamics and social, ethical and technical challenges, this helped to maintain quality of the discussions (Carter et al., 2021).

3.7 Sampling

A total of sixteen mothers and twelve to sixteen midwives were sought for this study. In qualitative studies, the rules on sample size are undetermined, however sufficient data must be retrieved to answer the research question (Gill, 2020; Hennink & Kaiser, 2022; Sandelowski, 1995). Sample sizes used in qualitative studies are often smaller, because the methods utilised are concerned with gathering an in-depth understanding of a phenomenon as opposed to attempting to generalise findings to a larger population (Berndt, 2020; Dworkin, 2012). Saturation is deemed to be the most appropriate measure of assessing sample size in qualitative research (Morse, 2015; Sandelowski, 1995). Saturation is the point during data collection when no new data or insights emerge (Hennink et al., 2019). Achieving saturation is suggested to be a key component in qualitative research and assists in making data collection robust and valid (O'Reilly & Parker, 2013). I found that determining saturation levels for this study difficult which is a common issue (Hancock et al., 2016; Kidd & Parshall, 2000), particularly for early career researchers (Charmaz, 2006; Dwork, 2012). It is stated that achieving saturation depends on factors which may not be under the researcher's control including time, accessibility of participants and budget (Dwork, 2012, Rees, 2016). It is argued that the sample size in qualitative studies should be flexible and not predetermined, the goal should be to not make generalisations, but develop in-depth understanding with rich evidence (Staller, 2021). The issue with this study was the ethical requirement that stated the sample size and timelines should be provided (Baker & Edwards, 2017). This placed pressure on me to gauge a sample size to achieve saturation, which can become a tick box exercise (Varpio et al., 2017).

It is suggested that qualitative researchers should discuss why their sample size is adequate and sufficient to be transferable to other contexts and how this aligns to their research question and methodology (Morse, 2015). Although I made the decision to prioritise time and budget, key issues in this study, the breadth and scope of the research aims also needed to be considered. Bryman (2016) purports that a narrow research focus can be more easily contrasted with other groups in the same context therefore, justifying a smaller sample size for this study. Furthermore, Malterud et al. (2016; 2021) suggests that narrow research aims with sample specificity, established theory, a good interview dialogue and analysis strategy requires fewer participants. Attempting to achieve data sufficiency rather than saturation relies on whether a researcher's intention is to generate theory or

describe a phenomenon (LaDonna et al., 2021). As my study aimed to describe a theory a smaller sample was required than a study that aimed to create theory. The issue of quality was also relevant, advocated by Ritchie et al. (2013), who proposed that one occurrence of a piece of data or a code is all that is required for it to become part of the analysis framework.

Alternatively, interview length is a more useful indicator of adequate information than saturation (LaDonna et al., 2021). The more information a participant holds that is relevant to the study the lower the number of participants needed (Malterud et al., 2021). Therefore, it is suggested that saturation can be linked to number of interviews and focus groups, particularly for homogenous samples (Tight, 2023), this assisted in my review of the sample size. I was enlightened by Guest et al. (2006), who examined transcripts from interviews on a homogenous sample of West African women and found that saturation was achieved after twelve interviews. The similarity with the study population of African women and sample size to my study reassured me that I had an appropriate sample. However, my skill as an interviewer was critical to ensure that there was focus on the research topic, that probing questions were asked and that participants were encouraged to provide illuminative answers. I further determined a maximum sample size by reviewing a study which explored qualitative doctoral thesis abstracts in the UK and Ireland which found that the number of participants interviewed was between 1-95 with a mean of 31 (Mason, 2010). An exploration of alternative views was useful, as the limitations to saturation posed difficulty in determining when one had reached a point where no new data emerges (Morse et al., 2014). I wished to avoid the over collection of data, which could lead to redundancy and repetition, in an attempt to achieve saturation (Bowen, 2008).

Purposive sampling was employed to select participants who could answer the research questions, this decision was guided by quality and variables such as demographics of prospective women (Farrugia, 2019). I used criterion-based sampling to obtain the candidates who could provide the most credible information for this study (Creswell, 2014; Palinkas et al., 2015; Staller, 2021). The process involved identifying a criterion that was important to the research. Utilising this approach ensured that participants were selected that would have the knowledge and experience of the phenomenon.

3.8 Selection criteria

Nigerian women who have migrated to the UK in the last five years are at increased risk of maternal mortality, so they were recruited to this study (CMACE, 2011; Knight et al., 2023; Thiel et al., 2021). Studies have shown that mothers have an accurate recall of birth up to five years post-delivery, supporting a view that mothers would be able to reflect on their antenatal care experiences during the first year after birth (Simkin, 1991; Stadimayr et al., 2006; Takehara et al., 2014; Waldenstrom, 2003). Memories that have intense emotions such as giving birth can be remembered more easily (Kesinger & Ford, 2020) and remains in the long-term memory of women (Altuntug et al., 2023; Simkin, 1991; Topkara & Cagan, 2020). Hence, the inclusion criteria were women aged 18 years or older, primigravida[4] or multigravida[5] who had delivered a live baby in the last year, had received antenatal care in the UK and migrated to the UK from Nigeria within the last five years. Women were only included in this study if they spoke English, which was not an issue as the official language in Nigeria is English (Blench, 2019).

The exclusion criteria were women with any mental health disorders or preexisting medical conditions as these were not highlighted by maternal mortality reports as an independent factor for the Black African mothers who died (CMACE, 2011; Knight et al., 2023; Lewis, 2007). However, during data collection this was adjusted to only exclude women with existing mental health conditions as recruitment was difficult. Women who have had a negative birth experience such as a stillbirth have been found to have a high risk of retaining a negative memory of pregnancy (Rijnders et al., 2008; Stadimayr et al., 2006). This study aimed to obtain a true description of the phenomenon and so women were not recruited who had poor pregnancy outcomes, as this could adversely affect women's perceptions resulting in skewed findings. Due to possible acculturation, women who had previously resided in the UK or any other country outside of Africa were excluded to provide a truer picture of the phenomenon. However, one woman was included who had been in the UK for 18 months and had previously spent two years in the UK ten years ago to study in University: this was because the total time in the UK was still less than five years. Adhering to the inclusion/exclusion criteria assisted in keeping the study reasonable and addressed the research questions (Baxter & Jack, 2008). Midwives who had provided routine antenatal care to women in any setting participated in this study. Midwives who had only been involved in providing additional

[4] Primigravida- a woman or person who has not previously been pregnant

[5] Multigravida- a woman or person who has had one or more previous pregnancies

antenatal care to women were excluded. To avoid bias, any midwife who had been involved in recruiting women to this study were not invited to be a research participant.

3.9 Development of the interview schedule

The interview schedule incorporated the concept of cultural competency to address the research aims (see appendix 4). The conceptual framework that guided the components of the interview schedule were Campinha-Bacote's (2002) and Papadopoulos et al's (1998) models of cultural competency. These concepts were integrated into the interview schedule by incorporating components from each model. The interview schedule was reviewed by the Asian and Somali interpreters and Professional Midwifery Advocate/ Better Births Manager at one Trust. Stakeholder involvement in the research design facilitated unique contributions, and advice on issues that I may have overlooked (King et al., 2018; Moreau et al., 2023). In the feedback provided it was suggested that the questions were relevant, and it was thought that most midwives would not utilise cultural competency during antenatal care. In particular, the interpreters stated that as they had similar cultures to the women they would add additional information to the midwife's advice relating to diet and exercise. This feedback was utilised to further refine the questions in the interview schedule.

3.10 Development of the participant information sheets and consent forms

The facilitation of informed consent and confidentiality is a key ethical concern in research studies (Wiles, 2013; Beach & Arrazola, 2019; Klykken, 2022). In the event that midwives or women revealed poor practice, it was made clear in the Participant Information Sheets (PIS) (see appendix 5 and 6) and consent forms (see appendix 7 and 8), how this would be managed. In the past eight years, there has been reports of serious failings in maternity services at the Morecambe Bay Hospital (Kirkup, 2015), in Guernsey (NMC, 2014) and at Shrewsbury and Telford hospital NHS Trust (Ockenden, 2022). The issues raised in the Kirkup and Ockenden reports were failures to escalate concerns about poor practice and inadequate responses to adverse incidents (Kirkup, 2015; Ockenden, 2022). Issues of poor practice in maternity units has continued despite previous recommendations shown by the latest investigation in East Kent Hospitals maternity services, where there were failings to ensure the safety of women and babies (Dyer, 2022). The current climate in maternity services was considered when informing participants of the possible breaches to confidentiality during this research study. The open-ended nature of interviews and focus groups could have led to unexpected directions in the conversation leading to having to consider ethical issues regarding poor practices (Dempsey et al., 2016; Hoagwood et al., 2014). The ethics panel

stipulated that the PIS and consent forms should clearly address that confidentiality would be broken if poor care or practice was divulged. The possibility of women reliving what may be traumatic events was also considered. Qualitative studies that has voluntary participation may result in participants discussing traumatic events as this may be what drew them to the study in the first place (Lenton et al., 2021). Hence, there was a potential to reveal poor practices, in which event confidentiality would have to be broken. It was also important that participants were made fully aware of how the data would be utilised in this situation (Gerrish & Lacey, 2010; Kamanzi & Romania, 2019). Due to the sensitive information of the data, the potential risks to the research participants was made clear to the ethics panel that consent and confidentiality was prioritised (Dixon-Woods et al., 2016; Taylor & Rogers, 2019). Hence, redrafting of the PIS and consent forms was undertaken and although time consuming this provided me with an opportunity to ensure that informed consent was robust during this study. In addition, participants were made aware of the referral routes and support available to them from community groups, social services, and General Practitioners (GPs), if social/medical problems were identified. Consequently, an intensive review of the PIS and consent forms ensured these aspects were made clear to research participants.

3.11 Gaining ethical approval

Preparation for IRAS (Integrated Research Application System) submission begun after initial registration in December 2018. This included preparation of consent forms, the PIS, the qualitative protocol, a risk assessment, the interview schedule, the schedule of events and applying for sponsorship. I was ready to submit to IRAS by March 2020, however by this time the Covid 19 pandemic restrictions were in place meaning that there would be issues with conducting any data collection that was face to face. This was a reality for many doctoral students, whereby delays and stoppages to research studies was caused by the lockdown (Jackman et al., 2021). I was advised to consider taking a suspension as potentially there could be further delays to data collection caused by the pandemic, such as issues with accessing the research site and focus of resources on patient care (Mourad et al., 2020; National Institute for Health Research, 2020). Other factors to consider, common to doctoral students was the move to remote working, increase in workload due to preparation of new material and learning new virtual platforms, lack of peer support and caring responsibilities (Jackman et al., 2021; Myers et al., 2020). Subsequently, I suspended my PhD studies from April 2020 for 15 months.

3.12 Recommencing PhD study

Once I returned to my PhD studies in July 2021, I had a change to my supervisory team. This meant new relationships had to be forged and the disruption impacted on access to supervision whilst a new team was sourced which is highlighted as an impact on motivation in doctoral students (Cornwall et al., 2019; van Tienoven et al., 2022). A change in supervision meant having to familiarise my new supervisory team with my PhD study and a further review of the IRAS application. Another issue was changing the data collection methods which required adjustment to any potential restrictions to accessing research sites due to Covid 19 (Miki et al., 2020; Villarosa et al., 2021). This included updating the data collection methods to incorporate online or telephone interviews and online focus groups due to the pandemic. Final submission to IRAS occurred in September 2021. Traversing the IRAS application took several months, with three amendments in response to the Health Research Authority panel recommendations.

3.13 Barriers and gatekeepers

Once ethical approval was achieved contact was made with the Research and Development (R and D) department at each Trust. The IRAS approval letter had stipulated that each Trust would need to determine their capacity and capability for this research study. Once this was confirmed I could apply for full sponsorship from the University of Hertfordshire. All researchers need to obtain a “research passport” from UK NHS trusts where they intend to carry out research (Laterza et al., 2016; Stone et al., 2020). I was unprepared for the research governance process that I had to complete to gain access to the NHS sites. I had to apply for a research passport in one Trust, this should have streamlined the process so that as an academic I could have access to several NHS Trusts (Jonker and Marshall, 2011). Unfortunately, the second Trust stated that they would not accept a research passport from another Trust. This meant I was negotiating access with two different Trusts, who had different stipulations and requests. Time was lost when repeated requests for information was made for forms to be sent which had already been provided. Attaining a research passport has been found to be burdensome (Stone et al., 2020; Wilkinson & Wilkinson, 2019), particularly if the whole process has to be managed by one person (Laterza et al., 2016). Negotiating access was a particularly frustrating part of this PhD journey, I did not think about leaving my studies, but I regretted several times that I had chosen to explore a topic which required access to an NHS site. However, my passion and personal commitment to this study motivated me and strengthened my perseverance.

IRAS have to provide an opinion within 60 days of an application being submitted, however NHS R and D departments do not work to timelines which has been criticised as a flaw (Jamie, 2013; Laterza et al., 2016; Richardson & McMullan, 2007). It is suggested that R and D departments should aim to shorten the period required to grant access and streamline their processes (Imran et al., 2021; Stone et al., 2020). Junior researchers have been disadvantaged in terms of the amount of time required to gain ethical approval and access to research sites, meaning there is limited time for fieldwork (Jamie, 2013). Access to both Trusts took a period of seven months. Lessons learnt from this process was to engage with research offices much earlier whilst awaiting IRAS approval. On a positive note, I gained skills in navigating and understanding the process with the R and D department and research governance which would be useful for future research projects.

Recruiting the mothers was difficult due to the strict inclusion criteria and having no direct access to Information Technology (IT) systems in both Trusts due to data protection requirements. I had acquired a research passport and research site access by the R and D department of each Trust and was required to adhere to their data protection processes. Initially, I sourced mothers on the postnatal ward who fit the inclusion criteria, by speaking to postnatal midwives. I handed out the PIS to mothers on the postnatal ward and an expression of interest form. In addition, I left the PIS and expression of interest forms with the discharge midwife to give to mothers on the postnatal ward. However, I had no response from mothers using this approach. I realised that newly delivered mothers may have a lot of demands on their time and being approached to partake in a research study with a new baby may have been inconvenient. As my inclusion criteria included Nigerian mothers who had given birth to a baby within the last year, I had to consider how I could reach women who had been discharged from hospital or even midwifery care.

Nigerian mothers were sourced with the assistance of a midwifery manager and IT midwife at one Trust and the postnatal midwifery manager at the other Trust who were able to access and review discharge records. Due to data protections purposes, I did not have direct access to any mothers' hospital notes or computer records. I provided the inclusion criteria to the midwives who were able to source appropriate women. I contacted mothers by phone and informed them that I was a midwife researcher at the Trust undertaking a study of their antenatal experiences and sought permission to text them the PIS. I allowed approximately a week for mothers to read the PIS before contacting them by text to see if they wish to take part in the study. I only contacted mothers who responded to my message and stated that they were interested in taking part in the study. I offered

mothers the choice of a venue that they felt comfortable with, either in their homes, or at the hospital, online or by phone. If mothers gave permission to be interviewed, I texted a consent form which I asked them to sign and return back by text message. All of the mothers contact details who agreed to be interviewed were stored with a designated number with names removed in a secure server. Any mothers who declined to partake in the study had their contact details deleted. I was conscious of how I approached mothers during the study and the importance of ensuring that their identities were protected. Mothers were assured that this was a research study that did not seek to reveal their personal circumstances but to provide a platform for them to talk about their experiences. Consent was sought again before the start of each interview and reassurances given again that any identifying information would not be revealed in any reports of the findings. I asked mothers at the end of each interview if they wished to be sent a summary of the research findings, all participants consented to this.

3.14 Research phases

Phase one-Focus groups

I conducted the focus groups first in order to follow a systematic approach and also utilise any information gained from this process, to refine the interview schedule for the women participants. I attended each Trust several times in person to gain consent. This was conducted by speaking to midwives individually in the antenatal clinic and the community midwives' office and sending out emails to community midwives and managers. I conducted two focus groups from each Trust consisting of four midwives using Microsoft (MS) teams. This was less than the original plan of six to eight midwives per focus group. Due to personal and work commitments of potential participants, recruitment proved to be difficult, and it took several weeks to acquire sufficient numbers for each focus group. One concern was the lack of guarantee that all recruited participants would attend for the focus groups. It is recommended that researchers should over recruit by 10-25 % (Rabiee, 2004). However, although seven midwives were recruited for Trust one and eight midwives for Trust two, four midwives attended each planned focus group at the designated time as non-attendees had unexpected work commitments. Smaller focus groups are becoming increasingly popular, due to difficulty in recruitment and more opportunity for participants to talk (Krueger, 2014). Decreased numbers in focus groups are also beneficial when participants have a great deal to share about the topic or have lengthy experience (Krueger, 2014). Although, it is advised that face to face focus groups work well with four to ten participants, online focus groups are stated to be more efficient with

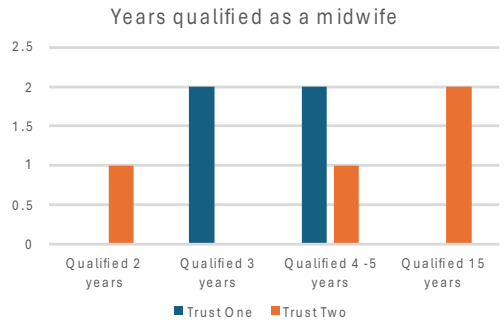
three to five participants (Lobe, 2017). If the issue being discussed is more complex then fewer participants are recommended, as the level of interaction is more important than the number of people (Lobe, 2017). I had already anticipated that if a smaller group of participants attended the focus groups they would still be conducted as valuable data could still be collected.

Verbal and written consent was obtained from all participants. All consent forms were signed face to face for the focus groups apart from two participants who were recruited face to face but sent their signed consent forms by email. Once consent forms were received these were stored in a secure server and the email deleted. A link for the focus group was sent to participants by individual email with an additional copy of the PIS. Consent was revisited at the start of each focus group as problems can arise from the degree of disclosure (Sim & Waterfield, 2019). During focus group discussions it is difficult to predict what participants may choose to divulge or they may be swayed into answering questions which they are unable to veer away from. Therefore, it was reiterated at the start of each focus group that participants could divulge only matters that they felt comfortable with. Midwives were given the option of having their cameras on or off during the focus groups, this resulted in one participant in Trust one opting to have their camera on, but in Trust two, there were two participants who left their cameras on. I commenced the focus groups by informing midwives that they would be recorded but that the recording would be deleted once the meeting had been transcribed. However, MS teams has a function that informs all participants that meetings are being recorded. Additionally, midwives were informed that the meeting was confidential and that everyone's privacy should be respected and the discussions from the focus group should not be revealed outside of the meeting.

3.15 Characteristics of midwives

The midwives came from a variety of backgrounds, Afro-Caribbean, Black African and White British. All midwives had qualified in the UK, with years of experience ranging from two years to over 15 years (see figure 3 1). All midwives had experience of providing routine antenatal care, with three midwives not currently providing antenatal care. Two midwives were in case-loading teams, three midwives were working in the community, and the remaining midwives (n=3) had different clinical positions (clinical placement facilitator, clinical governance midwife and antenatal matron) (see table 6 1).

Figure 3 1: Ethnicity and years qualified of midwives across both trusts



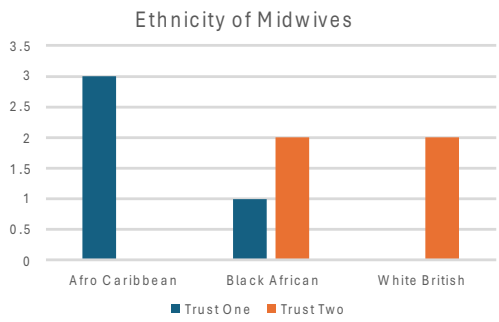


Table 6 1: Trust, ethnicity, experience, and years of qualification

Trust one	Ethnicity	Routine antenatal care experience	Years Qualified
MW1	West Indian	Currently case loading midwife	3 years
MW2	West Indian	Previous case loading midwife 2 years ago	5 years
MW3	Black African	Currently Community midwife	3 years
MW4	West Indian	Currently Community midwife	4 years
Trust two	**Ethnicity**	**Routine antenatal care experience**	**Years Qualified**
MW5	White British	Currently Community midwife	4 years
MW6	White British	Currently Case loading midwife	2 years
MW7	Black African	Previous routine antenatal care	15 years
MW8	Black African	Previous routine antenatal care	15+ years

3.16 Phase two

One-to-one interviews

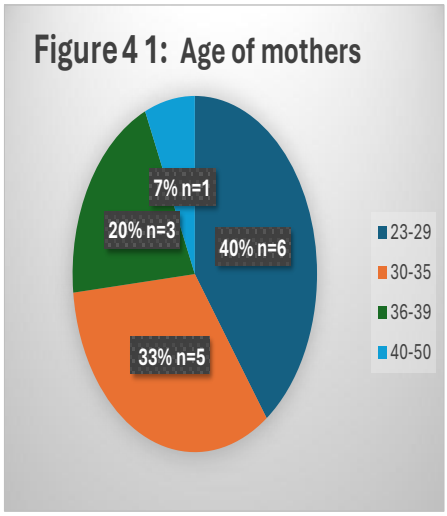
Fifteen one-to-one interviews were conducted face to face or by telephone, this was dependent on the mother's wishes, availability of a quiet suitable space, digital literacy and access to a computer and internet connection, to increase participation (Gill & Baille, 2018). To acquire information from the mothers, showing interest, being non-judgmental, active listening, paraphrasing, and probing were key tips used to facilitate this (Stofer, 2019). All mothers gave consent for the interviews to be audio recorded. This facilitated accurate transcription of the meetings (Gill & Baille, 2018), additional notes were kept on tone of voice, environment, any distractions and any unusual findings or issues with mothers understanding the questions. This tactic assisted with future interviews as difficult questions were rephrased and probes developed (Bullock, 2016). I reviewed the interview schedule before each interview and made notes during the interviews. It was important to be prepared and rehearse the prompts so that I could illicit a full response from the mothers. I also wanted to appear natural so that mothers would be more comfortable when answering my questions. The warmup questions were particularly important as I knew it was respectful in Nigerian culture to ask about the woman's family, her wellbeing and her baby's health before commencing the interview. Showing this respect helped to create a rapport with mothers. To not do so was a sign of disrespect and may have led to the mother not engaging fully in the interview. At the end of each interview, I encouraged mothers to talk about anything else they felt was relevant. Allowing this opportunity can lead to the discovery of unexpected information (Gill et al., 2008), which did occur in two interviews with women where they divulged information that had not previously been discussed. I reflected on the data collected at the end of each interview and compared this to the data collected in phase one with the focus groups.

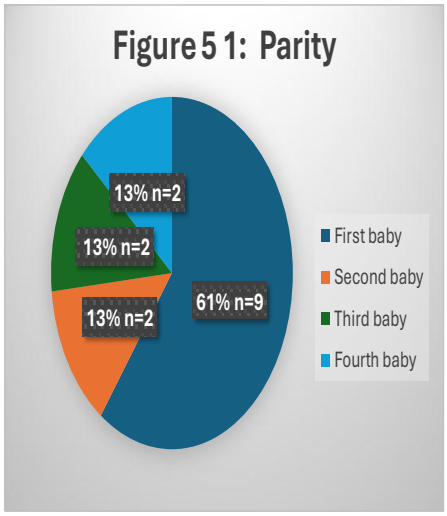
3.17 Characteristics of mothers

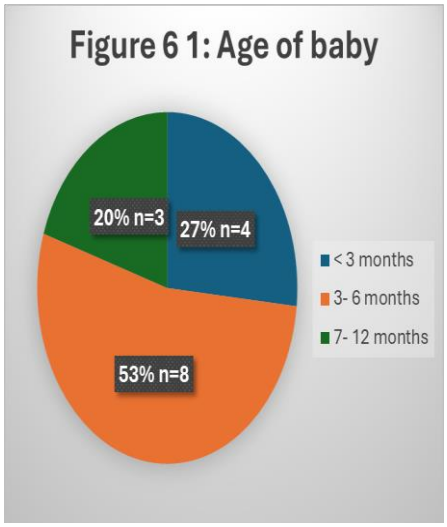
All mothers were 18 years or older and had been in the UK for less than five years (see figures 4 1-7 1). Seven mothers were already pregnant on arrival to the UK. Thirteen mothers were married, with one woman stating that her husband had remained in Nigeria. Two mothers were single, one mother did not divulge if she had been married, and the other mother revealed she had a boyfriend. All mothers resided with their children. Ten mothers were from the Yoruba tribe and five mothers from the Igbo tribe, two predominant tribes in Nigeria (see table 7 1). All mothers were given pseudonyms to protect confidentiality. The sample of mothers in this study was a good reflection of

the migrant population of Nigerians in England with 0.25% speaking Yoruba and 0.24 % speaking Igbo, and 0.06% speaking other Nigerian languages (ONS, 2021b).

Figure 4 1: Age of mothers, Figure 5 1: Parity Figure 6 1: Age of baby, Figure 7 1: Length of time in UK







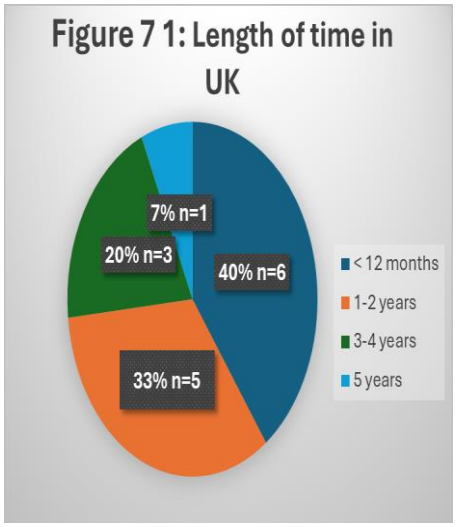


Table 7 1: Pseudonyms, Trust, parity, location of interviews, language, marital and educational status

Trust 1	Interview	Parity	Age of baby	Age	Length of time in UK	First language	Marital status	Education
Ozioma	Telephone	1st baby	Three months	<25	<12 months	Igbo	Married	University
Ola	In person (Trust)	4th baby	Two months	30-39	<12 months	Yoruba	Married	University
Ife	Telephone	3rd baby	Four months	40-45	<12 months	Igbo	Married	University
Temi	Telephone	1st baby	Seven months	25-30	12-18 months	Yoruba	Married	University
Tola	Telephone	1st baby	Seven weeks	<25	<12 months	Yoruba	Married	University
Toyin	Telephone	1st baby	Five months	<25	12-18 months	Yoruba	Married	University
Abi	Telephone	3rd baby	Six months	30-39	2-3 years	Yoruba	Married	University
Bola	Telephone	1st baby	Six months	25-30	12-18 months	Yoruba	Married	University
Trust 2	**Interview**	**Parity**	**Age of baby**	**Age**	**Length of time in UK**	**First language**	**Marital status**	**Education**
Yemi	Telephone	4th baby	Two months	25-30	12-18 months	Yoruba	Married [6]	University
Amaka	Telephone	2nd baby	One month	25-30	< 12 months	Igbo	Married	University education started
Yinka	Telephone	1st baby	Four months	25-30	< 12 months	Yoruba	Married	University
Tope	Telephone	1st baby	Three months	30-39	12-18 months[7]	Yoruba	Single	University
Chineke	Telephone	1st baby	Seven months	30-39	4- 5 years	Igbo	Single	Polytechnic
Lola	Telephone	2nd baby	Nine months	30-39	2-3 years	Yoruba	Married	University
Ngozi	Telephone	1st baby	Three months	30-39	2-3 years	Igbo	Married	University

[6] Husband in Nigeria

[7] Previously in UK, 10 years ago as a student studying for two years

3.18 Data analysis

Content analysis is commonly used in generic qualitative studies (Graneheim et al., 2017; Kahlke, 2014; Sandelowski, 2000; Vaismoradi et al., 2013). I used conventional content analysis to interpret the data, which is used in studies such as this, where existing theory or research is limited (Colorafi & Evans, 2016; Hsieh & Shannon, 2005). Only a quarter of the one-to-one interviews were professionally transcribed by a university approved transcription service due to cost. All professionally transcribed interviews were checked for accuracy, which is recommended practice (Bailey, 2008). The focus groups which had transcripts procured from the MS teams recordings were checked for accuracy. The same process was utilised with the one-to-one interviews where an audio recorder and MS teams were both used to record the fourteen telephone interviews and a face-to-face interview with one mother. I conducted transcribing of the focus group meetings before the interviews, which allowed me to gauge the current state of maternity services in the NHS and provided some context before the meetings with mothers. One issue of transcribing audio recordings is that they take up a large amount of time and this may impact on the quality of data analysis (Silverman, 2021). I found the process of transcribing the interviews lengthy which impacted on my motivation. To counteract this and to maintain quality, I only spent a few hours at a time when transcribing the interviews, allowing me some time to rest.

During data analysis, I found that NVivo version 12 was useful for organising the data. I was able to read through each transcript several times. This was an important act as reviewing and immersion in the data helped me to gain an overall feel for what had been discussed (Erlingsson & Brysiewicz, 2017; Morse, 2008). The two data sets were analysed separately, and data collection and analysis continued simultaneously. The aim of conventional content analysis is to focus on subject and content and draw attention to similarities and differences in the data (Hsieh & Shannon, 2005). The process of coding was conducted inductively, whereby the codes I used to label the data were developed based on the actual content of the transcripts (Vears & Gillam, 2022). I highlighted words or phrases that appeared to capture the key thoughts of midwives and mothers. I made notes of my first impressions and initial analysis as I reread and reread the transcripts word by word. This process facilitated in identifying codes, which emerged from the data (Hsieh & Shannon, 2005). As coding continued, codes were identified which represented more than one key thought and eventually became the initial coding scheme.

I made a conscious effort not to look for concepts. In this way the perceptions of the mothers and midwives remained authentic and real and were not lost during my analysis of the data. I assigned new codes to new words that did not fit into existing codes, I continued this process until all the transcripts were fully coded. The codes were then compared and contrasted to other codes and pooled into categories based on how they related to each other. These categories were grouped into themes (see figure 8 1 and 9 1). A theme is described as a unifying red thread that runs through several categories which brings meaning to the phenomenon (Graneheim et al., 2017; Morse, 2008). Themes describe behaviour, experiences or the emotions that occur throughout two or more categories (Kleinheksel et al., 2020). An example of how I derived a code from the raw data can be found in table 8 1. Demonstrating how codes and categories were derived from the raw data supported the rigour of this study (Graneheim & Lundman, 2004). I used content characteristic words from the categories to name the themes.

Figure 8 1: Process of doing content analysis

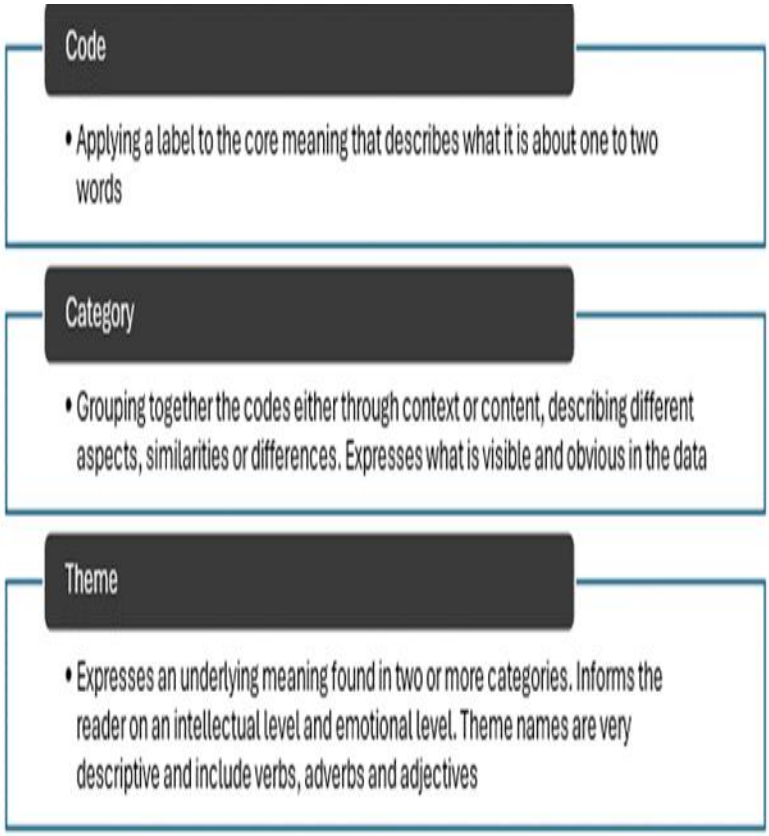


Figure 9 1: Example of categories and codes under theme of sharing but not exposing culture

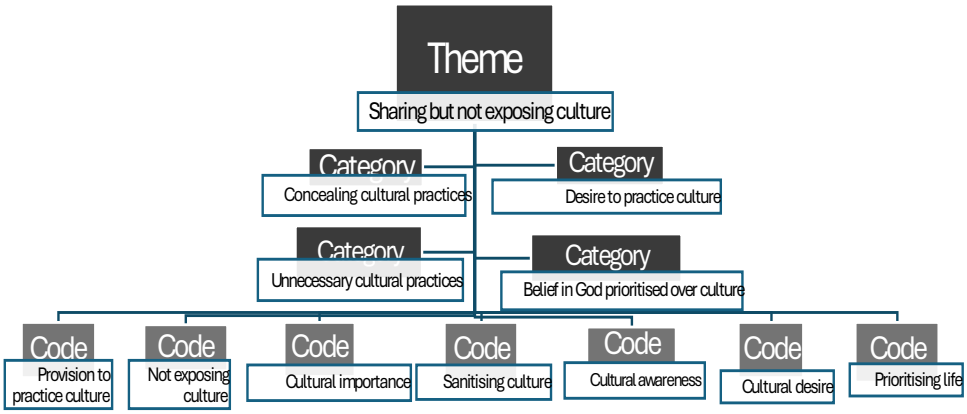


Table 8 1: Examples of developing a code from the raw data

Raw data	First impression	Initial analysis	Code
There is supposed to be inclusion of provision of that placenta in all those questions	My cultural practices were not included in my care	No provision to discuss my culture	Provision to practice culture
No, it's (culture) not important. I can't even expose where I am coming from.	Discussing my culture was unimportant	It was important to not expose my culture	Not exposing culture

The categories were reviewed several times to validate their presence in each theme. It was necessary to return to the raw data to reflect on the analysis and that the codes in the categories were still relevant. NVivo was a useful tool for re-reading the raw data and reviewing and rearranging categories and themes. During this time, I reflected on my understanding of the codes in each category and ensured that my personal views were not influencing how the categories were developed. Asking questions on why a category was put in a theme enabled emotional

distancing from the data and enforced my ability to take an objective view and at the same time preserve the subjective voices of the participants. Taking time away from reviewing the categories and revisiting the data assisted in maintaining this strategy. Irrelevant information was not immediately discarded but reviewed again to decipher meaning, in this way information that may have been missed was included and subsequently allocated to a category. Any information that was irrelevant e.g., delivery experiences of mothers were allocated to a separate theme (see appendix 13). Credibility was established by having prolonged engagement with the data (Hsieh & Shannon, 2005), by reviewing transcripts repeatedly when analysing the data and when I was writing the findings and the discussion.

Reflection

The process of coding the data was overwhelming at the start of data analysis. I was worried about putting my slant on the narratives from the mothers and midwives. Therefore, not showing a true picture of what they had revealed. it was helpful to continually go back and reread the transcripts. During the drafting of the findings chapter, I carefully reviewed quotes, and new meaning were illuminated leading to the creation of new codes and categories. It was a chaotic time, and I remember stating to my supervisor that my data analysis 'was a mess' and was reassured that this was a normal feeling.

3.19 Reflexivity

The researcher's position in qualitative studies has an impact on the way the research is conducted. This is known as reflexivity and is established as one of the ways in which qualitative researchers can ensure rigour and quality in their work (Teh & Lek, 2018). Reflexivity involves researchers clearly providing the context and relationship between the participants and themselves which increases the credibility of the findings and understanding of the work (Berger, 2015). Chafe's (2017) view that assumptions made about the topic of interest needed to be considered was a process that I frequently undertook. My background undoubtedly influenced the choice of topic and how I wished to undertake this study. Although, there was a definite belief that the participants' views were subjective and unique and could not be explored by certain approaches. My two decades of working in the NHS and caring for women and working with midwives guided my approach. Reflexivity plays a significant role in decolonising research, as it allows for a critical

examination of a researcher's epistemological assumptions and addresses power dynamics between researchers and participants (Thambinathan & Kinsella, 2021). I was aware of my position of power as a researcher and healthcare professional asking mothers and midwives to discuss their experiences. I tried to place myself in the position of the mother and midwives to see how I would appear to them in my actions and words and how I could remove any feelings of intimidation that they may feel during the interviews. Therefore, being aware of how I positioned myself during this research study was an ongoing process. In particular, answers received from participants were dwelled upon and I undertook deep introspection and further questioning, which assisted in colonised knowns being broken down into colonised unknowns (Barreiros & Moreira, 2019).

The insider or outsider position of the researcher is important in reflexivity. It is crucial to determine any shared experiences with research participants and particularly there should be consideration of any similarities and differences (Berger, 2015; The & Lek, 2018). I needed to be aware of these similarities and differences as the quality of the research study was dependent on this (Dodgson, 2019). The issue of maintaining reflexivity was important to consider during this study and how I would put aside any personal feelings, preconceptions and ideas which may have affected my decisions (A' Hern, 1999; Berger, 2015, Davis, 2020; Doyle, 2013). My background as a Black African midwife, also a mother, caring for Black African women and listening to their views and preferences had influenced my perception of the research problem and how I wished to study this phenomenon. Some of the mother's experiences were upsetting and I found myself comforting mothers and trying to show empathy. At times I was uncomfortable by the mother's reports of inconsiderate care and lack of empathy. I realised that as a researcher I would need to remain impartial during the research process, so reflexivity was important particularly in defining the boundaries of this study and considering the ethical implications of research outside of a defined methodological debate (Kahlke, 2014).

A researcher who shares similar attributes with the participants of a study is considered to be an insider, whereas a researcher who is not a member of the same group as the participants is stated to be an outsider (Clarke & Braun, 2013). As a second-generation Black African woman born in the UK, I may have been considered an outsider to the women I interviewed as they were first generation Black Africans, who had migrated to the UK and were born in Nigeria. The term 'part

time Nigerian' has been used to describe second generation Nigerians who are believed to not know the true nature of the culture and lifestyle in Nigeria. However,

I was born to Nigerian parents and attended secondary school in Nigeria before returning to the UK for further education. In this respect, I had an insider position as I had close links to the Nigerian community in the UK and had family in Nigeria. I embodied some values which were more prominent in Nigeria than in the UK. I interchanged between Nigerian culture when with my family and Nigerian friends and Western culture when at work and with non-Nigerian friends and colleagues. Therefore, the boundaries of my cultural identity was fluid and could vary depending on the context. There were some advantages to having an insider position, I had some knowledge of the cultural practices and beliefs in Nigeria. Some of the dialect women would use I was aware of as at times their English would be interjected with some local words or language. This would have posed difficulty for some researchers as they would not understand the context or meaning of some terms. Furthermore, the women participants may have felt more able to discuss their culture and beliefs, particularly taboos and hidden practices with a researcher from the same country. Nigeria has over 200 dialects and tribes however, there are some similarities in culture and customs. As I had undertaken some voluntary work in Nigeria within maternity settings, I was aware of how healthcare was conducted in Nigeria. Having an insider position may also have had some disadvantages as the women may have been cautious in discussing personal information with me for fear of this being divulged in their communities. Additionally, the women may have felt no need to provide detail in their responses as they were aware that I came from a similar culture.

An insider position was also useful as a midwife conducting the research with midwife participants as I was aware of the philosophy behind antenatal care and how it was conducted. This enabled me to ask pertinent questions and also be aware of the many variances of antenatal care due to previous work experience in this area. However, as I was not a Trust employee but worked in the role of a lecturer with students allocated to each Trust for their placement experience, there may have been some disadvantages. The midwife participants were aware that I was a midwifery lecturer and would be evaluating service provision and student safety and therefore, had a duty of care to report any poor practice. Additionally, there may have been concern that I would judge their clinical decision making and be perceived as someone who would be scrutinising their practice. However, at times I felt that my position was untenable and not fixed in any orientation. Dwyer and Buckle (2009) discusses the space between insider and outsider and that researchers cannot occupy one or the other of these positions. It is suggested that the intimate contact that researchers have with participants in qualitative research does not allow us to remain true

outsiders nor does it allow us to remain true insiders (Dwyer & Buckle, 2009). It is also stipulated that insider and outsider positions are dynamic and constantly changing depending on the context (Mason-Bish, 2019). This is further supported by Chhabra (2020), who purports that insider-outsider researcher's positionality cannot be sustained and is epistemologically controversial and methodologically untenable. Hence, it is advised that researchers place themselves in the role as an inbetweener who utilises the insider advantage to gain access and allow empathetic understanding but also to remove themselves from the position of an obtrusive outsider. This was in truth where I placed myself as neither insider or outsider but an amalgamation of both. It was important during this research study to constantly remind myself of my position as this could change depending on the context.

3.20 Trustworthiness

Guba and Lincoln (1989) provide criteria to demonstrate trustworthiness in qualitative research which are credibility, transferability, dependability, and confirmability. It is suggested by Caelli and Mill (2003) that credibility in generic qualitative research should address four elements, the theoretical position of the researcher, compatibility between methodology and methods that must not be in conflict with the epistemological and theoretical assumptions of the research approach, the analytical lens, and strategies to address rigour. Credibility was enhanced by utilising a qualitative descriptive approach to ensure that the data collection methods and analysis was appropriate for the research questions. Truth value is the recognition that there are multiple realities, and that the researcher discusses their personal views and experiences which increases credibility (Noble & Smith, 2015). Self-reflection is important in qualitative research as there is acknowledgement of researcher bias, and the attempts made to reduce this. Bias is implicit and mainly unconscious (Brownstein & Saul, 2016) and has impact on cognition and thought processes. Researchers may have a desire or wish to defend a view because they have a personal interest, without being intentionally misleading (Balcetis & Dunning, 2006; McSweeney, 2021). Therefore, I used field notes and a reflective journal to assist in recognising any personal biases which promoted credibility of research findings (Shenton, 2004). I also maintained reflexivity by keeping a reflective diary so that there was a clear documentation of the research framework and my decision-making processes (Berger, 2015; Johnson et al., 2020).

I promoted transferability by providing rich and thick verbatim descriptions of participants' accounts to support my findings (Coleman, 2022; Creswell, 2014; Slevin & Sines, 1999). I provided detailed

information about the setting, inclusion/ exclusion criteria, sample characteristics and data collection and analysis, so that readers could determine if my conclusions were transferable to other settings. Dependability can be achieved by providing a decision or audit trail that is clear and transparent, so that another researcher can come to the same conclusion (Sandelowski, 1993). A decision trail enables readers to form their own judgements about the quality and worth of a study (Johnson et al. 2020; Sandelowski, 1986). Therefore, detailed information of the sources and approaches I used in data collection and analysis, any interpretations made, decisions made, and personal influences were documented during this study. This aided in demonstrating truthfulness within the research findings (Hadi & Closs, 2016). Confirmability involves getting as close to an objective reality as possible (Stahl & King, 2020). Additionally, confirmability is strengthened when there is a clear link between the data and the findings (Stenfors et al., 2020), therefore, research findings are consistent and can be repeated (Connelly, 2016). Confirmability was achieved by keeping detailed notes of all decisions I made during the design of this study. I attended regular PhD supervisory meetings which involved discussion of notes and decisions made, this helped to reduce my biases, as different perspectives from my supervisors were reviewed (Connelly, 2016).

3.21 Chapter summary

This chapter has provided the rationale for adopting a qualitative descriptive methodology for exploring Nigerian mothers' and midwives' perceptions of cultural competency in antenatal care. The influences of Western research on studying non-Western individuals have been dissected and strategies used to recognise different ways of knowing. The methods used in each phase of this study, including sampling, recruitment, one-to-one interviews, focus groups, and ethical issues are included. The demographics of the participants has been described, and the strategies used to conduct the one-to-one interviews and focus groups. The process of conventional content analysis has been explained with examples of the raw data and how the codes and categories were derived. A reflection of the dynamics of coding the data and how any complexities were overcome, and the importance of reflexivity is provided. My insider/outsider position has been explained regarding cultural similarities and differences as well as professional commonalities and responsibilities. The next two chapters will discuss the findings and results of the conventional content analysis, providing quotes from the mothers and midwife participants, and field observations which helped to inform the research questions.

Chapter 4: Findings Phase One- Midwives

Introduction

The primary aim of this study was to explore migrant Nigerian mothers' and midwives' perceptions of cultural competency in antenatal care. The findings from this study are split into two phases. Findings from conventional content analysis of the data collected from eight midwives who participated in the focus groups are presented in this chapter. The next chapter will provide the anonymised findings from the fifteen mothers who participated in one-to-one interviews. Reflective notes that were kept during data collection are included and have been integrated throughout both chapters. A brief explanation is provided of two Trusts that were the research sites in this study to clarify the setting. The research questions are:

1. How do the perceptions of migrant Nigerian women differ from midwives' perceptions of cultural competency in antenatal care?

2. What are the cultural needs of migrant Nigerian women and how are their needs currently addressed within antenatal care provision in the NHS?

Phase one details the categories and themes derived from two focus groups with midwives. Each category is discussed under each theme and the underlying concepts are supported by narratives from the midwives. All themes are represented diagrammatically using a flow chart, to provide a clear presentation of the data. The concluding section provides a summary of the findings derived from the focus groups.

4.1 Structure of antenatal care provision in each Trust

Trust one had a migrant population of over 20% (ONS, 2019), based in a London borough which had a higher proportion of ethnic minority communities compared to the UK national average. The birth rate for Trust one's maternity unit was over 3000 per year. The maternity services comprised of a consultant led delivery suite, midwifery led unit, home birthing team, a dedicated operating theatre, recovery area, antenatal clinic, antenatal and postnatal wards, day assessment unit and a triage area. A Care Quality Commission (CQC) report in February 2023, stated that antenatal care was delivered through continuity of care teams for complex and vulnerable women, community midwifery teams and the antenatal clinic. In Trust two, the ONS mid-yearly estimates for 2019

showed that over 40% of the borough's population was born outside the UK (ONS, 2019). A CQC report in 2021 stated a birth rate of over 4000 per year in the maternity unit. The Trust provided most of its routine antenatal care in a central booking and antenatal clinic based in the hospital, antenatal care was also offered by the community midwifery and case loading teams.

4.2 Research findings- Focus groups

Four midwives from each Trust attended a focus group. During both focus groups there were some technical issues where participants were logged out of the meeting and had to be called back in, this occurred only for a few minutes. In Trust one, a midwife joined the meeting ten minutes late, so the questions already put to the other participants had to be repeated. Each focus group lasted for approximately an hour and there was adequate time to have a full discussion with every midwife given an opportunity to speak. The dynamics of the groups were observed during the focus groups, reflective notes were kept including the complexities of managing a focus group and my disappointment that some of the participants were unavailable. The analysis of the focus group data resulted in the creation of 91 codes that were used to form 17 categories which were further condensed into four themes (see Table 9 1). The themes were: antenatal care in the midst of cultural ambiguity; creating a space for sharing of cultural understanding; preserving culture and individuality and cultural hesitancy and impediments to antenatal care. Table 10 1 shows which category from each theme was discussed in each focus group.

Table 9 1: Themes derived from focus groups

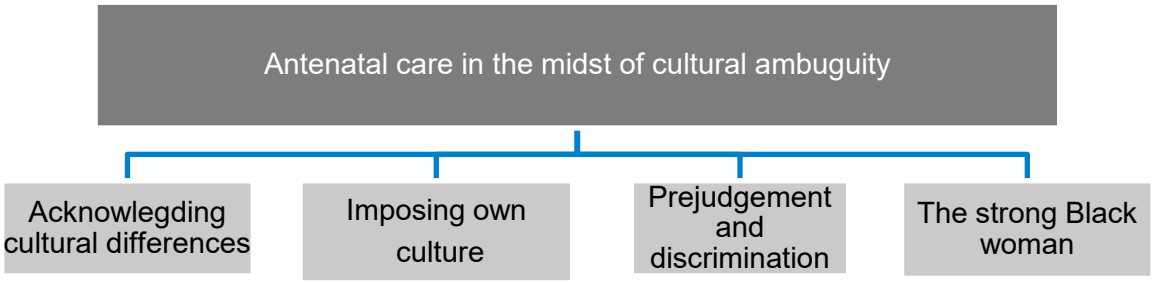
Theme 1: Antenatal care in the midst of cultural ambiguity	Theme 2: Creating a space for sharing of cultural understanding	Theme 3: Preserving culture and individuality	Theme 4: Cultural hesitancy and impediments to antenatal care
•Categories	•Categories	•Categories	•Categories
•Acknowledging biases	•Asking women questions	•Adapting care for women	•Service challenges
•Imposing own culture	•Having an open approach with women	•Managing women's expectations	•Family issues
•Prejudgment and discrimination	•Creating time for women	•Promoting women's empowerment	
•Cultural misconceptions of the strong Black woman	•Listening to and hearing women	•Sharing information and learning from each other	
	•Building a rapport with women	•Building a picture of women's needs	
	•Cultural desire		

Table 10 1: Categories discussed by each focus group

Category	Trust one	Trust two
Acknowledging biases	X	X
Imposing own culture	X	X
Prejudgement and discrimination	X	X
Cultural misconceptions of the strong Black woman	X	
Asking women questions	X	X
Having an open approach with women	X	X
Creating time for women	X	
Listening to and hearing women	X	X
Building a rapport with women	X	X
Cultural desire	X	X
Adapting care for women	X	X
Managing women's expectations	X	X
Promoting women's empowerment	X	
Sharing information and learning from each other	X	X
Building a picture of women's need	X	X
Service challenges	X	X
Family issues		X

4.3 Theme 1: Antenatal care in the midst of cultural ambiguity

'…there tends to be like an inner culture misconception of, you know that for example, the strong African woman that shouldn't really complain.'



Connotations about culture which could lead to misunderstanding and misinterpretation during antenatal care provision are presented in this theme. The impact of this on a woman's pregnancy was recognised by midwives as being a challenging time during antenatal care provision.

Acknowledging cultural differences

Cultural awareness which is self-reflection of one's own cultural and professional background and how this differs to others (Campinha-Bacote, 2002), was demonstrated by the midwives during both focus group discussions. All midwives were aware of cultural differences and failure to mitigate or accept this was acknowledged to be a potential barrier to individualised care. The importance of self-awareness of cultural beliefs and values and how this could influence antenatal care for women was confirmed by midwives. This was regardless of the length of training, as demonstrated by MW 3 and MW 7:

'I think it's also important…and like trying not to impose your own culture on other people as well. So being aware of your culture… because that can have impact on… their birthing experience and that could be potential negative impact...' (MW 3, qualified three years)

'it's about us knowing our cultural beliefs when providing care for other women... It is important for me to be aware of my cultural belief because our values and our beliefs, you know, play a good part, huge part even in our professional lives, social lives, and the way we interact with others, and the way we see them.' (MW 7, qualified 15 years)

Midwives acknowledged that women may have a different culture to their own when it was identified that they were from another country. This information would be retrieved during the booking interview or during routine antenatal appointments. Midwives spoke with conviction about being aware of differences which reflected the fact that they worked in a maternity unit that catered to a very diverse population. During my Trust visits I observed the range of diverse pregnant women in the waiting room of the antenatal clinic in both units. The posters on the wall denoted women of different ethnicities and the pregnancy information leaflets on display were translated in different languages. It was no surprise to me that the response would be positive to acknowledging cultural differences as all midwives had been working in London for at least two years. It was accepted during the focus group discussions that differences between the midwife's culture and that of the woman could cause issues in providing appropriate care. It is affirmed that unconscious bias is an adjunct to cultural awareness and therefore an inhibitor to developing cultural competency (Gopal et al., 2021). Understanding unconscious bias can assist the health professional in identifying judgments in clinical practice that can impact negatively on the service users (Gopal et al., 2021).

Reflection

I noted that midwives were very certain in their responses to the question: 'do you think it is important to be aware of your own cultural beliefs and values when caring for women from different cultural backgrounds' with answers such as ' yes, definitely,' 'it's very important,' 'I think so.' These responses were not surprising, as to say otherwise would be stating that you lacked competency as a midwife. After the meeting I wondered if I could have phrased the question differently to gender different responses.

Some of the midwives had alluded to professional culture needing to be considered as well as the personal culture of the midwife. Emphasis on providing care that should not be hindered due to biases was mentioned several times, as discussed by MW 1:

> *'I think it's very important… purely because we're gonna have biases, whether they're conscious or unconscious of women from certain ethnicities, and we have our own beliefs within our culture.'* (MW 1, qualified three years)

All midwives except for one had undertaken unconscious bias training, it was reported how this clarified personal perspectives of cultural differences, as the following quotes from MW 2 and MW 3 demonstrated:

> *'I agree like with the unconscious bias training…and it was really good to just explore that… and you know the group was all diverse, and so it was really good ...'* (MW 2, qualified five years)

> '*It was just interesting going through it myself, if that makes sense, because I think a lot of times we all kind of like we know about our bias, but we don't necessarily know who it impacts or how.'* (MW 3, qualified three years)

It was confirmed by the midwives that having training was helpful as this highlighted that everyone had biases. Importantly, there was a view that training assisted in self-reflection and revealing hidden biases.

Imposing own culture

Imposing midwives' culture on pregnant women was discussed as being a risk during antenatal care provision, as this could be the same as enforcing care on women. Imposing or enforcing care was described as being in conflict with midwives' professional values. It was believed that midwives would not intentionally force a woman to undertake treatment or follow a plan for her pregnancy. However, through the discussion in both focus groups imposing cultural beliefs was seen in practice albeit unintentionally. Midwives acknowledged the significance of enforcing care as MW 1 discussed:

'Yeah, what I wanted to add … it's really important that we kind of in regard to what (name) is saying, cause some women will have the same let's say religion, but they will practice it differently or they wouldn't be as devout as others. So, it's important for us not to kind of impose our idea of their religion or their culture on them.' (MW 1, qualified three years)

Imposing cultural beliefs on women from different ethnicities was stated to be a potential issue due to conscious or unconscious biases. This was highlighted by one midwife who discussed how the presence of biases could potentially lead to enforcing care on women:

'…it's very important (that) *I understand what they are, so that my unconscious bias or my belief does not then prevent me from providing individualised care for that woman. I have to provide care that is really bespoke and specific to that individual woman. So, I think that's very important.'* (MW 7, qualified 15 years)

As highlighted in the quotes from midwives, the discussion in both focus groups explored the concepts of unconscious bias and cultural awareness and how these contributed to culturally competent care.

Prejudgement and discrimination

There was a debate in the focus groups on how prejudging women could influence antenatal care provision and impact on the woman's cultural values and beliefs. It was recognised that prejudgment could affect the relationship between the midwife and the woman. The language used to converse with women was considered important, particularly conversing in a non-judgmental manner. Prejudgment was explored in two ways by midwives, the first as creating a barrier to caring for women universally. This was articulated by MW 3 who discussed the importance of not judging women so that they were able to express their wishes regarding cultural practices:

'*It could also affect relationships because then people might think that you are prejudging them based on things that they might not actually practice.'* (MW 3, qualified three years)

Secondly, prejudgment was stated to be a precursor to stereotyping which could impact on individualised care. Stereotyping was alluded to during both focus groups and how this could have a detrimental impact on planning antenatal care. Midwives provided examples of how stereotyping

could lead to culturally inappropriate care, and how being mindful of this was critical, as demonstrated by MW 6 and MW 7 in the following quotes:

> *'not …to create sort of stereotypes and cliches, you know and not going to assume that just because one African woman told me, oh, this is what we do, I'm not going to then assume that, you know, every African woman I look after wants to do it as well*.' (MW 6, qualified two years)

> *'... However, it's very important to know that yes, I have this idea in me and when people walk in or you are providing care for somebody who is totally different from you, it's knowing …that previous knowledge…should not hinder the care you should be providing.'* (MW 7, qualified 15 years)

Midwives' conversation introduced the issue of discrimination in the context of maternal mortality reports, highlighting the elevated risk of mortality among Black women compared to their White counterparts (Knight et al., 2023). Discrimination was raised not only as an issue between individuals from different ethnicities but also between people from the same backgrounds, as reported by MW 4:

> *'We've heard of that in many reports, especially with… the take five campaign, where women were being discriminated by the, you know, people from their own kind of races, not so much like an interracial like problem, but inner racial.'* (MW 4, qualified four years)

Other midwives from the same focus group agreed with this contribution, all midwives were aware of the risks to ethnic minority women during pregnancy. Two of the midwives worked in case loading teams, which was the recommended model of pregnancy care advised to reduce health disparities for high-risk women (NHS England, 2016). It was reported that even case loading midwives struggled to provide equitable care to women. A discourse occurred around the contribution of discrimination to poorer pregnancy outcomes. It was acknowledged that treating women fairly was key in providing appropriate antenatal care regardless of their ethnicity and cultural background. MW 7 stated this vehemently:

> *'I don't think it really matters however, but I think we should be fair in treating everybody like equity justice, whoever you're seeing, no matter where she comes from, you should be able to, you know.'* (MW 7, qualified 15 years)

Misconceptions: The Strong Black woman

Cultural misconceptions of the 'strong Black woman,' were highlighted in the focus group in Trust one as being an issue in care provision. The discussion around this concept was passionate and was derived from a midwife's personal experience of childbirth as well as from clinical practice. MW 4 reported:

> *'…there tends to be like an inner culture misconception of, you know that for example, the strong African woman that shouldn't really complain, and when they do complain, these are not taken as seriously.'* (MW 4, qualified four years)

This view was supported by another midwife who added that Black women being viewed as strong contributed to poorer pregnancy outcomes, was common knowledge. Midwives provided examples from clinical practice that were conducive to this opinion. Midwives tried to mitigate the impact of this myth by warning Black women who they were caring for to be aware and to speak up, as discussed by MW 2:

> *'…I would say to them that you know with these reports, Black women and Asian women and other minority ethnic women have poor outcomes, and so it is important to be aware and to ask questions when you don't understand.'* (MW 2, qualified five years)

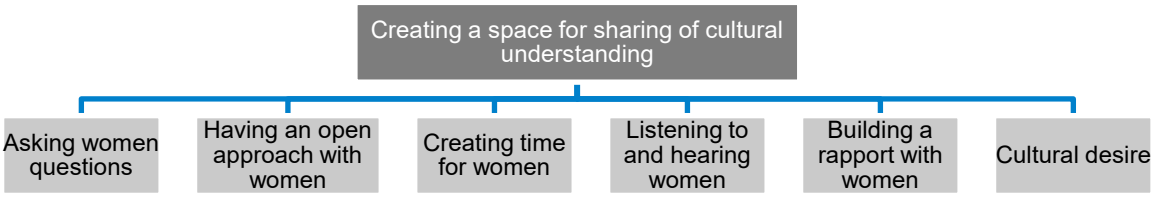
These views from midwives were conveyed with conviction and passion. The focus group in Trust one, consisted of midwives who identified as being of African and Afro Caribbean descent. I noted that the 'strong Black woman' concept was not reported in the focus group from Trust two, which had a mix of African and White British midwives. Despite midwives using tactics to inform women that they needed to raise any concerns about their pregnancy, there was an assertion that Black women were more likely to be ignored when they asked for help. Dismissing women because of their ethnicity was raised as an issue by midwives, as necessary care was denied. Midwives revealed that lack of attention to a woman's concerns led to mistrust. It was reported that mistrust had also been increased by the FivexMore campaign against Black maternal deaths and the

disproportionate deaths during the Covid pandemic (Fivexmore, 2024; Knight et al., 2023). Midwives believed that mistrust contributed to Black women not seeking timely healthcare and were passionate about changing this view, MW 4 discussed championing women to trust them:

> *'… I just think personally sometimes there can be a mistrust from our Black communities with their services. I'm not sure if it's because of mistreatment within the services, but it's like building that kind of rapport and confidence for them to let them know that we are on their side, if that makes sense.'* (MW 4, qualified four years)

4.4 Theme 2: Creating a space for sharing of cultural understanding

'Maybe specific questions. If there's some things she wants done in a specific way that will help me to establish what her cultural likes are to be able to sort of facilitate her own needs and choices.'



Midwives utilised various skills in an attempt to understand the woman's cultural wishes during antenatal care provision. Cultural skill is an ability to collect relevant information from individuals to perform culturally appropriate assessments and provide appropriate care (Papadopoulos, 2006). Strategies ranged from asking questions, having an open approach, and taking time to listen to women.

Asking women questions

Asking questions was the most common approach used by midwives to elicit information from women. Midwives from both focus groups stated that asking questions was important when caring

for women from different cultures as this allowed them to explore any beliefs and values they had about pregnancy. Therefore, emphasis on encouraging the woman by asking questions was an important skill. One midwife provided an example of a woman who was from Nigeria who this approach was used with, resulting in the woman becoming very engaged in the conversation. This midwife divulged how this allowed the woman to discuss a personal issue:

> *'… she asked can I talk to you about FGM' …..'so, I said yeah you can talk to me about FGM, and she said how do I know if I've had it.'* (MW 6, qualified two years)

The midwife was able to explore this concern as it appeared that the woman had not been able to talk about FGM with her mother but was concerned that her genitalia may be different. In addition, midwives confirmed the importance of asking questions so that they could learn for their own professional development. It was stated that this learning would help in understanding another woman who had the same beliefs or same rituals. It was also suggested that asking specific questions would help to establish what a woman's wishes were, as stated by MW 7:

> *'Maybe specific questions. If there's some things she wants done in a specific way that will help me to establish what her cultural likes are to be able to sort of facilitate her own needs and choices…Communicating with the individual, yes.'* (MW 7, qualified 15 years)

Having an open approach with women

An open approach and demeanor was mentioned several times by midwives in both focus groups as being a facilitator to allowing the woman to talk**,** as discussed in Trust one by MW 3 and MW 4:

> *'…just having like a very open… approach to everything… and just letting them kind of asking a lot of open-ended questions. So even though we have like the booking question, sometimes I tailor it to allow them to just talk, which is good because…we have a lot of time in our continuity team to kind of do that.'* (MW 3, qualified three years)

> *'I think just your approach in general and your communication and just being kind, caring, compassionate um if you come across like that, women tend to be quite open with you*

regardless .They tend to trust you… especially if the communication is very open and honest.' (MW 4, qualified four years)

This was also confirmed by midwives in Trust two, who reiterated the importance of being open:

' We have to have (an) *open disposition. We have to appear to be approachable. We must appear to be respectful and welcoming, you know, because… if you want somebody to feel comfortable with you, to speak to you about whatever that matters to them, then they have to see it through you,' (*MW 7, qualified 15 years)

It was further stated that the lack of an open approach could lead to the woman not engaging with antenatal care and advice. MW 7 stated that a woman may be encouraged by the midwife being approachable and be willing to engage more fully in the process:

'…*they will go along anyway and do what they want because they are adults, and they will live their lives the way they deem it fit...'* (MW 7, qualified 15 years)

Midwives were aware that there may be hidden beliefs and views that women may not share due to a fear of being judged. An open approach was seen as a way of embracing women and welcoming their views.

Creating time for women

Midwives debated the benefits of learning about a woman's culture which could lead to an increase in cultural knowledge, but this was only possible if time were allowed to do this. The lack of time during antenatal care was a common theme during both focus group discussions. This was verbalised in several ways, examples such as **'***a huge barrier'*,' '*women not having things done,'* '*don't have enough time with women,'* were reported by midwives. The acquirement of cultural knowledge was discussed as being an important aspect of a midwife's skill set when caring for different communities. Cultural knowledge is recognised as a crucial component of cultural competency and similar to the midwives' views can be learnt either from learning from or caring for different communities (Papadopoulos, 2006). Creating time for women to increase midwives' cultural knowledge was a tactic used during antenatal care. Midwives utilised spare time to allow

the woman to talk at the start of the appointment. It was reported that midwives were not always given enough time to talk to women but could only provide the basic care, this was particularly for women who were not in a case loading team. MW 4 explained the issues with managing time during antenatal appointments:

> **‘***But actually, when you look in general community women, you know the midwives don't have enough time… to listen to women. They literally just have the basic time to get on with… the physicality of the appointment and send those women off. So, a lot of women feel quite dissatisfied with their service.’ (*MW 4, qualified four years)

This view was supported by MW 1 who was a case loading midwife but would at times cover for a general community midwifery team:

> *‘I've also covered an antenatal clinic for community and some of the women didn't have things done that was supposed to* (be) *done… It's like the appointment is so quick. Lots of things are skipped and the documentation as well is not to a high standard.’* (MW 1, qualified three years)

The views of midwives in Trust one, contrasted to reports by a MW 6 in Trust two, who discussed her role as a case loading midwife who looked after recently migrated women and how she had time to explore the woman’s culture:

> *‘You know, I have the time in my job, I'm quite lucky… to just sit there with them and just ask them, you know, why is it that you do that? Why is it that you practice that, just so that I can learn*…(for) *my professional development so that… down the line, if I have another woman who has the same beliefs or the same rituals, then I understand why.’* (MW 6, qualified two years)

Midwives were conflicted with trying to provide a good standard of care within strict time limits which impacted on quality. Frustration and resignation were heard in the midwives’ voices when describing their challenges of conducting good quality antenatal care with the time limits imposed by workload.

Listening to and hearing women

Listening and ensuring women felt that they were heard was disclosed in both focus groups as being relevant in routine antenatal care. In the narratives, reference to poorer pregnancy outcomes were made when women's concerns were not acknowledged. MW 4 discussed the impact on not listening to women:

> *'What tends to happen, what I've witnessed, and actually what I've read in terms of reports of, you know, these women that had had suffered like massive repercussions in terms of like … not being listened to.'* (MW 4, qualified four years)

Maternal mortality reports and the increased risk for Black and Asian women (Knight et al., 2023) have been associated with missed opportunities to listen to women when they highlighted their concerns. Missing voices was a key feature in the 2022 maternal mortality report, where it was reported that women struggled to engage with maternity services and action was required to understand and work with women (Knight et al., 2023). MW 2 discussed how she would highlight to women with the use of leaflets during their antenatal checks, that they should be listened to:

> *"…so, I would highlight that to them… that they're listened to, and if they don't feel listened to, contact me as their named midwife.'* (MW 2, qualified five years)

Further discussion revolved around listening being a sign of respect and a valuing of women's concerns, hence midwives believed this facilitated sharing of information. MW 2 and MW 7 had similar views on the importance of showing respect to women by listening to their views:

> *'… Sometimes it is just the women want to be heard… I think that's showing respect …where you're listening asking questions and not coming from a place of…not patronising them as well. '* (MW 2, qualified five years)

> *'…ask them questions respectfully and listen as everybody has been saying …they will speak to us more and they will even go out of their way to tell us more than we have even asked them.'* (MW 7, qualified 15 years)

Listening was also reported to be a valuable skill to increase cultural awareness and showed the woman that her wishes and desires were being heard. MW 5 and MW 6 provided reasons why this was an essential component of antenatal care provision:

> **‘***But just make sure that you're sitting. You're listening, you're understanding… I think it's nice to just be able to sit there and allow them to kind of offload it to you and then you're showing an interest…from my experience, they kind of like that. You're showing an interest into their beliefs.* (MW 5, qualified four years)

> *‘…You know, no one can be expected to be completely aware… of everyone's full catalogue of possibilities. But... It is about listening.’* (MW 6, qualified two years)

Listening and ensuring that women know that their views are heard, is a facilitator for shared decision-making which is stated to be a key component of universal personalised care (NHS England, 2024). It was identified that listening to women's preferences was significant and contributed to the establishment of culturally competent care. This was particularly when there was a clash of opinions or professional conflict with the choices the woman wanted to make as discussed by MW 7:

> ‘…*let her make that decision, have that shared decision making. So, it's about showing that actually I have heard you…I know evidence-based information. It might clash with this. It might not sort of all go well. What do you think? Or can we meet you halfway? We'll see how we can balance this since it is so important.’* (MW 7, qualified 15 years).

MW 6 who had a caseload of women who were recent migrants advocated the need to listen to women but reported difficulties with how personal wishes could be accommodated. Attempts to provide shared decision making led to the dilemma of being caught in an ethical and professional conflict:

> *‘…most of my women that I see at the moment in my caseload are from the Islamic Community and I have as many, kind of saying I am fasting and they're not, you know, asking me about it.… women asking me if it's OK to fast and it's then also trying to be aware of, well are you asking me as a professional or are you asking me, you know, are you asking for permission kind of thing...’* (MW 6, qualified two years)

Negotiating with women about cultural or religious practices that was in conflict with professional judgment was divulged by MW 6, further hampered by this midwife's cultural background of White British origin, which she stated led to a concern that she was seen as an outsider. Sharing ethnic origin was seen as an advantage by other midwives who stated that having the same cultural background as the woman helped to build a rapport, it was felt they would listen as they had a similar culture, as described by MW 1 and MW 3:

> *' If we're the same race, it helps a lot as well because they feel like we're listening to them at times, if that makes sense.'* (MW 1, qualified three years)

> *'…so, in terms of my own personal experiences just with African women, I think when I'm case loading and not just at (Trust one), but when I'm case loading in my previous Trust as well, I think a lot of the African women that I've met are usually from West Africa or South Africa… my name is very Nigerian I think that it helps* (to) *build a rapport as well.'* (MW 3, qualified three years)

Midwives discussed the benefits of building a rapport with women and how this could strengthen communication. It was accepted that the skill of listening was an isolated one if the woman would not divulge information. It was also acknowledged by midwives that there could be some cultural issues that are very sensitive to the woman and creating an environment that was not intimidating was necessary:

> **'***We create rapport with other people…if you want somebody to feel comfortable with you, to speak to you about whatever… matters to them…'* (MW 7, qualified 15 years)

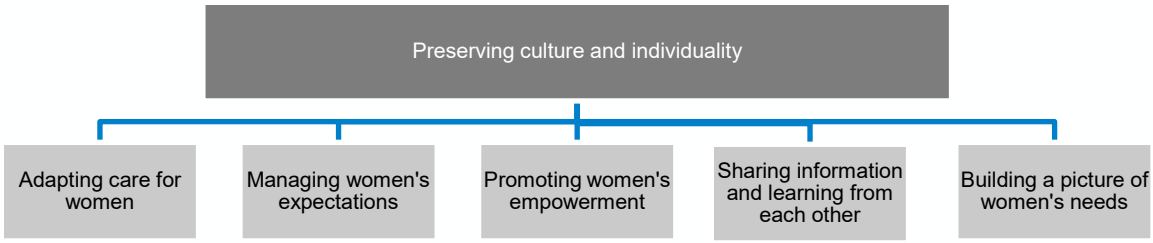
Cultural desire

Midwives in both focus groups wanted to engage in the process of being culturally aware and culturally knowledgeable, which is a crucial component of cultural competency (Campinha-Bacote, 2002). Cultural desire was evident from the midwives' responses, although not referred to explicitly, the general discussion around asking questions, creating time, listening, and being heard and building a rapport alluded to a desire to learn about a woman's culture. Words such as '*being receptive ';* '*so that I can learn;' 'open disposition;'* '*opening your mind,'* were declared by midwives which demonstrated a wish to engage with other cultures. My reflective notes documented that the midwives enjoyed their roles, this was evident from the passion heard in their voices during the

focus groups. I also noted that the number of years qualified did not impact on this as the midwives with two to five years' experience were just as passionate as the midwives with 15 years of experience.

4.5 Theme 3: Preserving culture and individuality

> *'…we might see someone that we've not kind of had an experience* (of) *that culture before. So, it's just really important that we're able to be adaptable.'*



Cultural sensitivity was revealed in the midwives' discussion, which is an ability to be supportive of people from different cultures (Papadopoulos, 2006). Midwives were actively engaged in meeting women's needs, which is an essential component of cultural sensitivity (Claeys et al., 2021). Midwives discussed tenets of cultural sensitivity by supporting women's cultural values and organising care to meet their expectations, preserve their culture and protect their individuality.

Adapting care for women

Facilitating the wishes of women when the midwife was made aware of a cultural practice was discussed in both focus groups. Terms such as **'***asking what they're used to,' ' how you can adapt the care,' 'able to be adaptable,'* were verbalised by midwives. Examples of how care was adapted to meet the cultural needs of women were discussed, as reported by MW 5:

'…in birth plans…sometimes we'll discuss with women that they want to keep their placentas for after they've had the baby and for cultural reasons they wish to plant it and they wish to take it home, cook it.' (MW 5, qualified four years)

Further to this MW 6 recalled an intrapartum experience where she tried to facilitate a mother's wish:

'… They really wanted to bath the baby, and I was, I just sort of did my best to facilitate it. I wasn't kind of saying, you know, we weren't doing it because I didn't have time, it wasn't my job. But we don't normally do it…and I was told, you know, we are African and it's what we do.' (MW 6, qualified two years)

This midwife when on to state that some customs and rules cannot be accommodated, and it was important to explain the reasons to the mother. Another midwife expanded on this point about encouraging women to '*tell us things'* rather than keeping the issue hidden as this may be an important aspect of the woman's care:

'…*if they feel we ridicule at whatever it is they are going to say, then they might just keep it, and it might be actually a vital part of the care we provide for them….I'm just thinking of rituals or generally and what people like to do.'* (MW 7, qualified 15 years)

NICE (2021), recommends the initial booking interview should be conducted by ten weeks of pregnancy to improve pregnancy outcomes. MW 7 also discussed the cultural practice of women hiding their pregnancy which may result in the woman booking after the recommended gestation. However, MW 8 in the same focus group acknowledged that women may conceal their pregnancies due to other reasons and explained the steps she would take to adapt care for a woman who was not attending for antenatal care:

'…*I think the first thing I should do is probably depending on her pregnancy gestation to call her and find out what the problem is, because sometimes it might be childcare... and then maybe if it's childcare, you can … book an appointment for her where it's possible for her to attend. So, the first thing is to find out why is she not attending and then hopefully work around that.'* (MW 8, qualified 15+ years)

Midwives stressed during both focus groups that acquiring information on cultural practices was a keep component for individualised care. The explanation provided by midwives demonstrated cultural skill and sensitivity, and professional accountability. Midwives were adamant that regardless of culture, individualised care should be prioritised for all pregnant women, as articulated by MW 1 and MW 5:

> *'…Just respecting their culture, maybe trying to understand more we can always ask them, do research. So...when they say something that we could possibly incorporate or something we couldn't possibly incorporate, discuss with them why we can't do this or why it's gonna be difficult to do this or that.'* (MW 1, qualified three years)

> *'… I think we're planning their care for that whole pregnancy…you know, taking into consideration and there are loads of different cultural beliefs, loads of different ethnicities out there, loads of different religions. So just need to make sure we are catering for everyone individually and just making sure that they all have, like, individualised pathways really for their care.'* (MW 5, qualified four years)

Additional needs in pregnancy range from pre-existing or emerging complications during pregnancy (NMC, 2019). There was a discussion around adapting care for women with additional needs with consideration of their cultural beliefs. One midwife discussed her experience with a woman who had to attend multiple appointments and how trying to allow her to observe her culture proved to be difficult:

> *'…I guess if we was faced with like cultural beliefs and reasons why they couldn't come into the hospital regular then, yeah, we would do our midwife visits at home… in terms of diabetic appointments, in terms of scans, in terms of doctors, in terms of attending Maternity Assessment Unit for checkups…we need to just make sure that they're getting care from all aspects of maternity …we kind of adapt to a women's needs in a very different way obviously due to their vulnerabilities.'* (MW 5, qualified four years)

The general consensus from midwives was that care would be adapted if there were no contraindications and there would be a discussion with the woman about coming to a compromise, as described by MW 7:

'It should not prevent you from being an advocate for your client and doing what is best for her.' (MW 7, qualified 15 years).

Managing women's expectations

Midwives disclosed experiences of managing a woman's expectations during antenatal care, particularly during the booking appointment. It was accepted that women's expectations may differ according to their cultural beliefs and values. Discussions around how these expectations could be explored were evident in the focus group discussions, MW 2 reported:

'I would sort of give them an opportunity to then sort of…you know…discuss any kind of concerns that they might have or differences in what the expectations are… if there were challenges and from the other side in terms of cultural challenges I'd want to understand what they were and how we could meet halfway.' (MW 2, qualified five years)

Midwives recognised that migrant women had complex socioeconomic circumstances related to adapting to a new country and healthcare system. One midwife acknowledged that women may have expectations that may be unrealistic to meet in the NHS, but it was still important to manage these. MW 3 provided an example of the reasons why she paid attention to recently migrated women during antenatal care provision:

'I've had, like, recent migrant couples and this was again not in this Trust, but I spent about an hour just explaining the NHS…and they would explain their system to me … in terms of their model of care…then it helps to … not only manage their expectations but also understand what their expectations are in terms of their care with us.' (MW 3, qualified three years)

Managing migrant women's different expectations of which healthcare professionals provided antenatal care was also discussed by the focus group in Trust two, as reported by MW 5:

' I found sometimes with women in their own countries, they don't have antenatal care.... a lot of people think that the doctors deliver the babies, and midwives don't deliver babies,

and this is kind of like a common thing with asylum seekers…They don't want midwives in the room…' (MW 5, qualified four years)

Midwives also revealed the importance of managing women's expectations particularly if they were lower to the care standard that was available in the UK. In one woman's case due to a condition that needed closer monitoring in pregnancy she received more antenatal appointments than she had with her previous pregnancies. MW 6 shared this woman's experience:

' …I've got a lady on my caseload at the moment who is actually sort of kind of the opposite to what you've been describing and what you will expect…So, she's getting a lot of care…She's actually very surprised and almost sort of…not annoyed. She's being invited to a lot more appointments than she was expecting to be because she's saying in her country.. she said we never see doctors. You have a midwife and that's it.' (MW 6, qualified two years)

Promoting women's empowerment

Empowering women leads to improved pregnancy outcomes and is considered a benchmark of quality midwifery care (WHO, 2015). Empowerment was discussed from two viewpoints, the perspective of the midwife and the perspective of the woman. Empowering women to practice their culture and having their values respected was viewed by midwives as a basic requirement in midwifery care. Midwives provided different words to define empowerment, such as allowing women to '*express their needs,'* '*enhancing their journey,'* and '*control*.' MW 1 discussed her perception of empowerment and how this influenced the care provided to women:

'I think it's important that we make them feel empowered…so we can kind of, yeah, empower them to ensure that they get the birth experience, antenatal care and personal care that they desire.' (MW 1, qualified three years)

Midwives communicated how the ability to empower women could be enhanced by certain factors, such as sharing a similar background to the woman or being of the same race. It was felt that women saw this as a positive sign and enabled the facilitation of self-advocacy. MW 1 described a

conversation she had with a woman who stated that she felt empowered to be surrounded by Black midwives and Black doctors:

> *'…one woman … she actually commented that when she looked up and was surrounded by… Black women she felt empowered. So, it's like the doctors were Black, the midwives, Blacks …, it helps a lot as well because they feel like we're listening to them at times, if that makes sense.'* (MW 1, qualified three years)

Midwives also talked about the need for women to be aware of their maternity rights as this could aid empowerment. A midwife expressed that *'women can put pressure on themselves'* which led to them not receiving the required standard of care. This was supported by another midwife in relation to care in labour and her experience of women not asking for help. The NMC code of professional conduct states that healthcare professionals should act as advocates for service users (NMC, 2018). Midwives emphasised a professional responsibility to encourage women to seek support and the importance of advocacy.

Sharing information and learning from each other

Midwives were aware of the importance of sharing information with the women, this was seen as a two-way process. It was disclosed that women may hide information from the midwife because of their cultural beliefs and values. Providing as much information to women was seen as one way of covering any questions that the woman may have and also encouraging her to ask more questions, as articulated by MW 8:

> *'…it's about us giving them as much information as possible because when you give somebody information, that's where they start asking questions...'* (MW 8, 15+ years qualified)

Ensuring that information was shared at an appropriate level for the woman to understand was also deemed important, according to MW 8:

'… All that is being said, is right, but you know just making sure that we are giving them as much information as possible and always, in a layman's language for them to understand what we're saying…' (MW 8, 15+ years qualified)

Sharing of information with the woman was considered to be an important aspect of increasing cultural knowledge and professional development. Midwives also discussed the value of learning from women and being exposed to other ways of doing things when caring for individuals from other cultures. MW 1 conveyed the relevance of learning from women:

'…It's been quite helpful and also just..., understanding that we can learn, we can learn from each other and understand like I said previously that even though certain women (are) from the same country, they may not have the same beliefs.' (MW 1, qualified three years).

I noted the partnership working revealed by the midwives in their responses that demonstrated inclusivity and sensitivity. Regardless of the cultural differences, midwives valued the knowledge they could gain from women to support them on her pregnancy journey. This was verbalised succinctly by MW 8:

.' So, it's about… making that woman know that she's a partner in that care, you know, so bringing her in and walking that journey with her…' (MW 8, qualified 15+ years)

Building a picture of women's needs

Midwives disclosed that building a picture of a woman's individual needs was required to provide holistic care. It was acknowledged that having cultural awareness and knowledge assisted the provision of holistic care, as it was necessary to acquire knowledge of certain practices that women would undertake. Midwives employed certain strategies to facilitate this, such as utilising the booking appointment to explore the woman's cultural needs:

'…you've got the booking questions, but in that there are other questions that I would ask as well just, you know, to find out about her and other individual needs that she may have or things that are important to her.' (MW 2, qualified five years)

During provision of antenatal care, it was revealed by midwives that they became aware of some antenatal and postnatal practices and traditions that women were required to observe. The importance of these cultural traditions were recognised by midwives and understanding women's cultural needs. Lack of awareness around traditional practices were thought to not be beneficial in helping women to observe their culture. MW 1 and MW 3 disclosed their experiences:

> *'There's a lot of cultures that kind of… people wanna do things after they deliver baby, and we do need to be aware of these things if we're not aware.'* (MW 1, qualified three years)

> *'…some cultures have traditions where pregnant women or people* (who) *have just given birth should not do certain things.'* (MW 3, qualified three years)

Midwives routinely enquired about cultural practices to ensure that the woman and her baby's health were not compromised. There was awareness that harmful practices could only be advised against if there was knowledge. Cultural knowledge has been advocated as a catalyst for cultural negotiations and a platform for providing evidenced based care (Esegbona- Adeigbe, 2011). The midwife remaining neutral regarding cultural practices was disclosed as a stance that was adopted to avoid conflict with women, as reported by MW 4:

> *'…I think if it doesn't affect…you know, their care, that doesn't need to be …necessarily be mentioned.'* (MW 4, qualified four years)

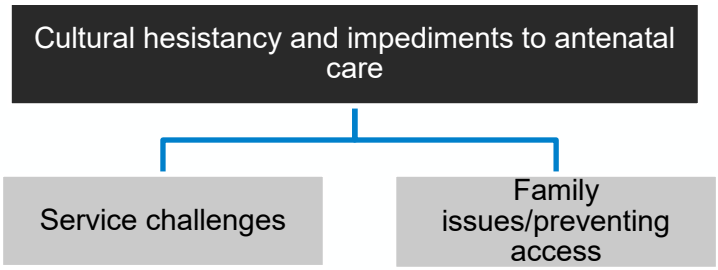
It was noted from the focus group discussions that midwives were certain about some cultural practices that would not be sanctioned such as FGM.

Reflection

I reflected on the midwives' responses regarding sanctioning harmless cultural practices. However, I had knowledge of some cultural practices that may fall into a grey area and how these may be allowed by one midwife but not another. Therefore, this would pose difficulties for some midwives. A further difficulty was how to discuss with women avoidance of harmful cultural practices in a sensitive way. As this was something I had struggled with in the past. I was conscious of how disrespect could be inadvertently caused. I empathised with the midwives who reported that they had been in this cultural limbo on a regular basis.

4.6 Theme 4: Cultural hesitancy and impediments to antenatal care

'It is like the structure of how we work needs to (be) improved a lot more.'



Impediments to providing culturally appropriate care were disclosed by midwives and how this led to hesitancy from women when accessing or engaging with antenatal care. The views from midwives were varied and complex, revealing the impact on providing quality maternity care. Issues that were raised were a mix of social, professional, and organisational factors, demonstrating the breadth of the problem. These issues were similar in both Trusts and was reported by midwives to be present in other Trusts in London.

Service challenges

Midwives outlined several challenges when attempting to provide culturally sensitive and appropriate antenatal care. It was revealed by midwives that the NHS was under pressure and antenatal care provision were bound by financial constraints and workforce limitations. The structure of maternity services was mentioned several times in relation to discrepancies in antenatal care provision. One midwife stated:

> *'It is like the structure of how we work needs to improve a lot more, especially with appointment times for many* (of) *our general community. But yeah, we've done amazing, amazing work with the continuity* (of care), *but there's a massive disparity between the care that women receive from the continuity of care teams and actually the care that they received in the general community, which is for most of our women. So, I think that (disparity)… needs to be fixed because really all women should be receiving the same sort of care.'* (MW 4, qualified four years)

Midwives disclosed that more continuity of care in the community would improve the support available to women. Another advantage of having continuity of care teams was the flexibility of where to deliver care, highlighted by one midwife who revealed that she could facilitate a woman's needs by offering antenatal care in her home. However, it was acknowledged that other aspects of women's requirements during antenatal care such as obstetric involvement and ultrasound scans could only be delivered in the hospital. So, midwives recognised the challenges in catering for the woman who was not engaging with antenatal care. Midwives indicated that women who declined care from a male healthcare professional for cultural reasons may also have less access to maternity care. It was debated by one midwife that '*90% of obstetricians are male,'* therefore, there was a potential to miss necessary obstetric input due to the lack of female doctors. It was disclosed that if there was availability of a female doctor then this would be facilitated as much as possible to reassure the woman that her cultural beliefs were valued. MW 5 described the issues with women requesting female healthcare professionals:

> *'… but most of the time in terms of people's religious beliefs and… cultural beliefs, they don't wish to be looked after by male staff. So just female staff, which obviously is quite difficult … in our hospital we do have a lot of male staff ...'* (MW 5, qualified four years)

MW 4 worried about the high-risk women who declined male professionals as it was believed that this may lead to their care being compromised:

> *'It's the same thing with like…not wanting to be cared for by male professionals…we do tend to make a note of that even on the system, however, we need to be realistic with the cover... and obviously in case of an emergency we will not be fit to care for that family.'* (MW 4, qualified four years)

Provision of female interpreters to cater to women's wishes was also reported as a challenge by midwives, and unavailability of certain dialects from interpretation services. Midwives tried to facilitate women's cultural preferences, but this was complicated, as reported by MW 4:

> *.'…we've had couples kind of asking for specific gender translators…that happens like quite often, which is quite difficult, especially in certain languages, because they're quite unpopular languages in terms of the variety of translators.…we acknowledge their preferences. However, I do need to be realistic with the services we run.'* (MW 4, qualified four years)

It was revealed in Trust one, that a majority of complaints were due to non-availability of translators that were acceptable to the women. Midwives explained to women the issues with translation services, and often juggled appointments or utilised whatever translation services were available at that time, MW 4 explained the dilemmas she faced:

> *'They don't have like… a massive variety of translators, so I tend to explain, you know, what the situation is and letting the family know that unfortunately, you know, if you want things to run in terms of safety and making sure the translation is… done appropriately, not by like a family member, if possible.*' (MW 4, qualified four years)

Midwives knew that they had limited communication with women due to the diversity of languages spoken. Difficulties arose if the language that the woman spoke was not available, therefore despite having awareness that translation services should be used, this was not always feasible.

Family issues/ Preventing access

Family members preventing women from abandoning their culture by using tactics such as not allowing the use of mobile phones were reported by midwives. The buddy (pregnancy information) mobile application (APP) which midwives provided for women to download in Trust two, would be prohibited by some husbands. Midwives revealed that if the APP was downloaded, women were not allowed to access it. This was believed to be one method of preserving the woman so that they remained *'the way they are culturally.'* It was seen as a disadvantage by midwives if women were prevented from using the buddy APP by family members, as they were unable to have control over their pregnancy due to lack of knowledge. This point was discussed further by MW 7:

> *'…So, in that case then that impacts on the information that they're supposed to access…what should be useful for them during their pregnancy, they will not be able to utilise it…so it's clear that there is more education and awareness required to just make people…realise that this is* actually *educational. It's not to harm anyone or to make them abandon their culture or who they really are...'* (MW 7, qualified 15 years)

Other family related factors which impacted on women's access to antenatal care such as caring commitments and work and financial commitments were uncovered in the focus groups. MW 6 recognised how one newly migrated woman and her husband who she was case loading, had to deal with other issues that took priority over attending for antenatal appointments:

> *'It's difficult, and she also has the barriers of, you know, limited funds having two small children to look after…they're both trying to learn English… they're often attending courses, and her husband's also trying to work and it's really difficult.'* (MW 6, qualified 2 years)

Midwives offered solutions to some of the impediments to offering culturally competent care such as tailoring appointment times to suit the woman, rearranging appointments to cater for translators and forewarning women about potential issues with services.

4.7 Summary of findings

The views of eight midwives have been provided in this chapter together with excerpts from a reflective journal. Midwives revealed the importance of cultural awareness and knowledge, and the

skills and desire to be culturally competent. This ability was assisted by the cultural encounters available to them in their work settings. Midwives' experiences in providing antenatal care to migrant women highlighted the challenges and difficulties that impacted on their ability to embrace culturally competent care. These challenges ranged from language barriers, family gatekeepers and service constraints, particularly around current structure of antenatal care provision. It was apparent from the narratives from midwives that they juggled their professional accountability so as to cater for women's cultural needs. Significantly, midwives forewarning Black women about the current climate of Black maternal deaths in the UK, arose from the focus group discussions, and the strategies mothers should use to not become a part of these statistics. This revealed the role of the midwife as not just being a healthcare professional but unconventionally undertaking additional positions which were traditionally not part of usual midwifery practice. The next chapter presents the findings of 15 interviews with migrant Nigerian mothers.

Chapter 5: Findings Phase two - Nigerian Mothers

Introduction

This chapter presents the findings from 15 one-to-one interviews with Nigerian mothers. A total of 183 codes were sorted from the data analysis which were modified down to 23 categories utilising conventional content analysis. Several categories were renamed during this process as on re reading the transcripts the meaning of what the mothers were saying did not fit the category title. The 23 categories were sorted into eight themes (see table 11 1). The themes present the mothers' perceptions of cultural competency in antenatal care, hence answering the research questions.

The research questions were:

- How do the perceptions of migrant Nigerian women differ from midwives' perceptions of cultural competency in antenatal care?

- What are the cultural needs of migrant Nigerian women and how are their needs currently addressed within antenatal care provision in the NHS?

One additional theme was created from data that related to women's experiences during labour and did not directly add to this study (see appendix 13 1). This ninth theme related to mother's interactions with midwives during labour and delivery which was in addition to their antenatal care experiences. The categories and themes are discussed in the next sections. Excerpts from the mother's narratives are provided and to maintain confidentiality pseudonyms are used (See table 12 1). As in the previous chapter, at the start of each section diagrammatical representations of each theme and the categories are presented.

Table 11 1: Themes and categories from the one-to-one interviews with mothers

Themes	Categories
1. Overlooking culture during pregnancy care	Identification of migrant women (during booking antenatal care) Exploration of culture (with women during pregnancy)
2. Sharing but not exposing culture	Concealing cultural practices Desire to practice culture Unnecessary cultural practices Belief in God prioritised over culture
3. Cultural expectations of antenatal care	Seeking antenatal care Negotiating antenatal care Pregnancy care in Nigeria
4. Navigating pregnancy within two cultures	Experiencing life in the UK Adjusting to UK culture
5. Cultural opinions on information needs	Using the internet Asking family and friends Care between routine antenatal appointments and antenatal education
6. Essence of care versus cultural knowing and skill	Every woman is the same Feeling safe Cultural advice *'If you are Black'* (Risk of Black ethnicity and pregnancy)
7. Culturally embraced communication and interactions	Building relationships The importance of being listened to Speaking normal English
8. Respectfulness across cultures	Being respected (*Squeezing up her face*) Disrespectful behaviour

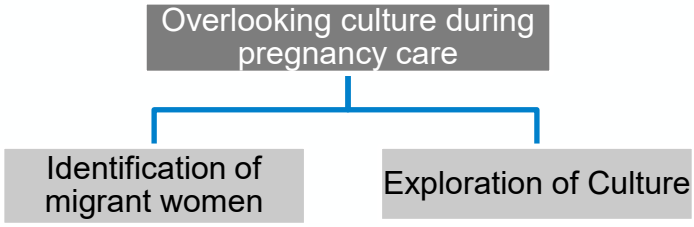
Table 12 1: Pseudonyms, parity, age of baby, mothers' age and length of time in UK

Trust 1	Interview	Parity	Age of baby	Age	Length of time in UK
Ozioma	Telephone	1st baby	Three months	<25	<12 months
Ola	In person (Trust)	4th baby	Two months	30-39	<12 months
Ife	Telephone	3rd baby	Four months	40-45	<12 months
Temi	Telephone	1st baby	Seven months	25-30	12-18 months
Tola	Telephone	1st baby	Seven weeks	<25	<12 months
Toyin	Telephone	1st baby	Five months	<25	12-18 months
Abi	Telephone	3rd baby	Six months	30-39	2-3 years
Bola	Telephone	1st baby	Six months	25-30	12-18 months
Trust 2	**Interview**	**Parity**	**Age of baby**	**Age**	**Length of time in UK**
Yemi	Telephone	4th baby	Two months	25-30	12-18 months
Amaka	Telephone	2nd baby	One month	25-30	< 12 months
Yinka	Telephone	1st baby	Four months	25-30	< 12 months
Tope	Telephone	1st baby	Three months	30-39	12-18 months[8]
Chineke	Telephone	1st baby	Seven months	30-39	4- 5 years
Lola	Telephone	2nd baby	Nine months	30-39	2-3 years
Ngozi	Telephone	1st baby	Three months	30-39	2-3 years

[8] Previously in UK, 10 years ago as a student studying for two years

5.1 Theme 1: Overlooking culture during pregnancy care

'I just think there was no discussion that made me think about it (culture)*. If I was asked, I think I would have said something. One or two things about it.'*



Disregard for the woman's culture was frequently conveyed by mothers in the interviews, two omissions were starkly highlighted, identification of the woman being a migrant and recognition of the woman's culture. In most of the interviews, mothers reported that their culture was not identified or focused on during the appointments. A majority of mothers saw different midwives during the course of their antenatal care, with some stating that they saw up to four midwives. Only two mothers declared that they had one midwife for all their antenatal appointments. Two mothers had transferred care from other London hospitals, as they had to relocate due to a change in housing. All the mothers discussed how the focus of antenatal care was on their general wellbeing.

Identification of migrant women

Mothers revealed that they believed that midwives would know that they were migrants and thought this was required information for midwives. However, the inconsistencies in the midwives' attention to the woman being a migrant were reported. Mothers were asked if the midwife was aware that they had migrated from Nigeria at the booking interview or at any antenatal appointments. Negative responses were: *'we didn't discuss that,' 'I don't think I had that,' ' I can't remember.'* In contrast, some mothers had positive responses such as: '*they asked me everything,'* '*yeah she knows,'* '*she was aware,'* '*yes, it was part of the questions.'* The antenatal booking interview is the most important meeting of the women's pregnancy since the necessary information required to plan the woman's care is obtained at this point (NICE, 2021). Midwives are

expected to inquire at the booking interview, the woman's place of birth, so this would have been an opportunity to discover that some mothers had recently relocated to the UK from Nigeria. Ife, who was pregnant with her third baby, was booked after 24 weeks of pregnancy and had only been in the UK for three months at the time of birth, was asked her place of birth during her booking interview but not why she had booked late:

> *' … yeah she asked me quite a lot – it took about 20 minutes or even more the first time she was taking my details.'* (Ife, third baby)

A booking after 20 weeks of pregnancy may have highlighted to the midwife that the woman was new to the area acting as a prompt for further discussion. Yinka was also over 20 weeks pregnant at the booking appointment, however, the reason for booking late was not explored with her:

> *'…well...actually we didn't have that discussion she only asked where I was born when I came in.'* (Yinka, first baby)

Similarly, Ozioma had booked after 18 weeks:

> *'… because I actually went with my medical reports that I got from Nigeria before coming… so she went through and reviewed.'* (Ozioma, first baby)

Some mothers assumed that the midwife would not need to ask questions about their country of origin and their migrant experience as it would have been documented in their medical records and case notes. This was articulated by Ngozi and Tope:

> *'…but I am sure definitely they would know because it is written in my….hospital book… but I don't know …because as I said I met different midwives yeah, so definitely they will know.'* (Ngozi, first baby)

> '*Just normal questions, but they didn't talk about anything regarding migration because obviously they can see that I was on a student visa.'* (Tope, first baby)

NICE (2021) recommends that women who book late should be asked the reason, as this may reveal social, psychological, or medical issues that need to be addressed. However, the

disconnect between mother's assumptions and midwives' enquiry into their migrant status was noted.

Reflection

I noted the disparity in mothers' responses on if they were asked about their migration journey and how many of the responses came as a surprise to me. Some mothers could not recall being asked, which I questioned further in a neutral manner, but received the same responses. I recall thinking that this was a lost opportunity as there may be time limitations in asking the mother about her migrant experiences at later antenatal appointments.

Exploration of culture

Mothers reported that no attention was paid to their culture by midwives: '*No, she didn't, discuss the differences,'* '*we did not discuss to that extent,' 'there was no discussion about it.'* Alternatively, some midwives were said to have only spent minimal time discussing the mother's culture. One mother distinctly remembered the midwife only discussing cultural beliefs in relation to male circumcision. However, this conversation was initiated by the mother because the midwife was also Nigerian. Another mother disclosed that the midwife discussed female genital mutilation with her. These were the only two instances where specific cultural practices were discussed with mothers. Repeatedly, midwives did not address the mother's culture, as revealed by Ife, Chineke and Toyin:

> *'No no, I can't remember anyone asking me about my beliefs - they only asked me my religion and that's it – Christian – when they are taking my information.'* (Ife, third baby)

> *'…* (They discussed) *so many things that I am not supposed to eat, something like that, I still remember that one, but they didn't say nothing. They didn't say nothing about that* (culture).*'* (Chineke, first baby)

> *'I don't think we had anything that had to do with culture.'* (Toyin, first baby)

Asking mothers about their religion is a mandatory question during the booking interview, this would have provided an opportunity to discuss any cultural beliefs as they are interlinked (Abdulla, 2018). The absence of emphasis on the mother's culture was accepted by mothers as normal during their antenatal care. Amaka was already pregnant when she arrived in the UK and suggested that as this was not her first baby, asking about her cultural beliefs and values may not have seemed relevant to the midwife:

> *'Well yeah, because like I said, it's my second baby, it's not like it's my first. It's not like it's a new thing for me, so like maybe that's why she didn't really ask.'* (Amaka, second baby)

Ife did state at first that she was not sure if it was important to ask about her culture, but she was '*open minded.'* However, after pondering over this, Ife divulged how a discussion about cultural practices may have been useful:

> *'Uh … because I've not had* (a) *baby here before that would have also been good too, if she can come up with anything this is how it's done here, this is how it's done, this is the comparison.'* (Ife, third baby)

Ola, who was pregnant with her fourth baby, discovered she was pregnant soon after arriving in the UK, supported the view that further discussion on her culture would have been beneficial. This view was strengthened when Ola had a consultation with an obstetrician who came from the same tribe and stated this made her '*happy*' as they were able to converse in their language and discuss her wishes**.** Up until this point Ola had been feeling frustrated with her antenatal care as her values were not being prioritised. It was noted that mothers who had arrived in the UK already pregnant had similar views. Temi who was approximately 16 weeks pregnant on arrival to the UK, stated that it would have been valuable to have been asked about her cultural beliefs and values, but believed that because her midwives were not Nigerian this did not occur:

> *'… I don't fault them for not discussing them … because they may not be aware of the practices… in Nigeria …if anything the people who really saw me for much of my appointments were not Nigerian.'* (Temi, first baby)

Ozioma, who had booked after 20 weeks of pregnancy also stated that she would have benefited from having her cultural beliefs and values discussed as she had been anxious about having her first baby in a new country:

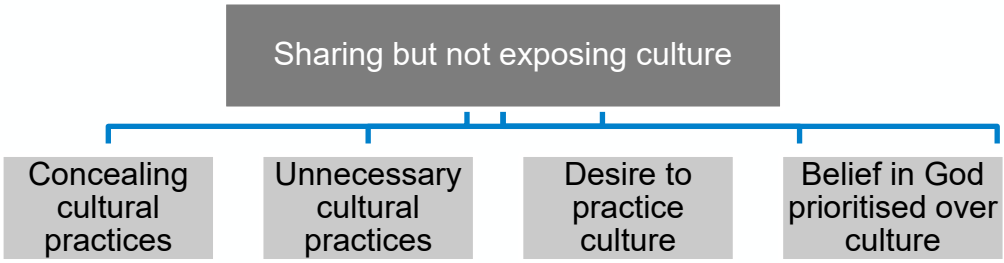
> *'it's important because you know when one is pregnant there are a lot of things that go through the person's mind – from labour what it's going to be, how long it's going to take – all this stuff. So, if she had asked me I think it would have helped actually calm my anxiety as of then.'* (Ozioma, first baby)

Bola had transferred her care from another London hospital due to housing and stated that her cultural beliefs and values were not explored at either maternity unit. She believed that having some discussion would have demonstrated that the midwife was generally concerned about her:

> *'Because I feel that it's a topic that should be discussed to know the present state…the culture here, just to be informed about the culture here, the practices here.'* (Bola, first baby)

5.2 Theme 2: Sharing but not exposing culture

> *'Ah you know, they say when you are in Rome you behave like a Roman…If I was in Nigeria….obviously you behave like a Nigerian.'*



Cultural encounters are necessary to develop cultural knowledge, awareness, and sensitivity (Campinha-Bacote, 2002). Mothers either exposed their cultural values and beliefs or these were

obscured or not observed. Mothers also restricted how much they discussed any cultural issues with the midwife. Routine antenatal care provides opportunities for cultural encounters; however, the effectiveness of these interactions were influenced by how much information was shared between mothers and midwives.

Concealing cultural practices

Mothers discussed cultural practices as not being essential now that they had relocated to the UK, this was conveyed in several ways with words such as '*no, it did not matter,' 'I was not interested in that,' ' it is not necessary.*' Tope's response when questioned further about why cultural practices were not a main concern was:

> *'…because I am not in Nigeria again. You understand what I am saying.' (Tope, first baby)*

This statement was accompanied by laughter, followed by a discussion on putting aside cultural behavior that may be considered illegal as it may harm the baby. Tope did not expand any further on what she meant by '*illegal*.'

Reflection

My reflections on Tope's response was influenced by my own experiences of Nigerian cultural practices. I did not question further about the use of the word 'illegal.' This was because some practices such as consulting witch doctors and spiritualists were common in Nigeria, resulting in having to undertake rituals. These are hidden practices which are not talked about and would not be divulged to outsiders. Due to my awareness of this being a hidden a practice, I did not seek further clarification, my insider position meant that I could understand the context of Tola's response.

Other mothers were negative in their need to practice their culture, as demonstrated by Yemi and Ife.

> *'It was not so important to talk about my culture.'* (Yemi, fourth baby)

'I haven't gotten involved with anything that has to do with my belief…because there was no time I would say oh I don't want this, or I don't want that.' (Ife, third baby)

Ola when asked what cultural practices she would have usually practiced, responded*:*

'No, it's not important. I can't even expose where I am coming from.' (Ola, fourth baby)

My reflective notes recorded that mothers evaded my questioning on their cultural practices. Despite my probing about why their culture was not a priority, it seemed that this was not a topic that mothers were interested in discussing. Ola's comment about not exposing her culture, was said with a look in her eye and a smile, which I returned. An unspoken signal was shared between us, which I recognised as a sign that we did not need to discuss this further, and I moved onto another topic.

Reflection

I noted in my reflections that regardless of length of time in the UK, mothers discussed how practicing their culture was not a main concern during pregnancy. I sensed a feeling that mothers were protective of their culture. As a Black African I already knew that I also protected some parts of my culture which was only shared with people of a similar culture. I thought deeply around whether I was unconsciously allowing my innate practice of not sharing my culture with outsiders to transfer onto the mother's responses. Taking a step back and examining mothers' responses confirmed that this was a genuine picture of the mothers' views.

Desire to practice culture

Mothers adhered to cultural practices based on how this was achievable during their antenatal care. Some cultural practices were adhered to or valued, despite mothers not discussing this with midwives. It was disclosed that pregnancy in Nigeria is not discussed with anyone outside of close family and healthcare professionals. This was presented as a means of protection for the mother and baby, as expressed by Tola:

'You don't really talk about it when a woman puts to bed she, puts to bed. Nobody has to know when she is due.' (Tola, first baby)

Tola discussed how she found it unusual for people unfamiliar to her to enquire about how many months pregnant she was and if she knew the sex of her baby. In Nigeria, Tola conveyed that women did not discuss their pregnancy or reveal the sex as this was a cultural taboo, even to healthcare professionals. Adapting to questions being asked about her baby was difficult as Tola did not want to cause offence, she realised that this was normal behaviour in the UK. A vaginal birth was also revealed as being a cultural norm in Nigeria as a caesarean section was believed to demote the mother to not being a real woman. These beliefs were concealed by mothers during their antenatal care but reported in the interviews:

'…and back home nobody (wants) *to hear about operation – oh no no no…So back home in my country people are very scared to hear that…you put to bed to operation…but here it's just normal… If you want to go for childbirth in Nigeria you don't want to hear that you will be going through operation.'* (Ife, third baby)

'…they always believe that every, every woman must not do CS (Caesarean Section) *.That you must have normal delivery. Which is in some cases it doesn't happen like that'* (Tope, first baby)

Mothers were asked '*did you wish to practice your culture at all,'* as I had received so many replies about not wishing to discuss culture. Most mothers gave negative responses to this question:

'Nothing…other than still eating my Nigerian food.' (Ozioma, first baby)

'Probably, because it's my first baby I was not expecting anything …I had to adapt to whatever it was I was taking here.' (Tola, first baby)

'I don't think that was the reason why I went there (hospital) *, so I don't think I was interested in that. You know, it was not something I wanted.'* (Ngozi, first baby)

In contrast, Ola wanted to keep her placenta for burial after the birth, she explained how this was not shared with the midwife as other discussions regarding her antenatal care were prioritised. Ola wished she had the opportunity to express her wishes before birth, unfortunately, no provision was

provided for this discussion during her antenatal care. Ola commented that '*some people are eating their placenta, so why can I not take mine.'* After the birth she stated that she had to '*overlook my mind,'* and allow the placenta to be discarded. Western medicine views the placenta as medical waste, but in Indigenous groups there are important rituals surrounding the placenta (Moeti et al., 2023). Most placenta rituals have links to future health predictions of the mother and fetus. In Ola's case she wanted to bury her placenta which is a common cultural practice (Chikako & Joseph, 2017), to ensure her baby's wellbeing. I recognised the importance of this ritual as I had similar beliefs in my own culture. So, I could emphasise with Ola and felt her sadness around the inability to perform this placental ritual.

Unnecessary cultural practices

Continuance of harmful cultural practices are linked to illiteracy or lack of formal education (Abebe et al., 2021; Zenebe et al., 2016). Mothers discussed cultural practices that were not beneficial during pregnancy. This was linked to educational level as mothers suggested that if someone was not educated then they would not know that treatment recommended by the midwife or obstetrician should be sufficient. It was explained that there was no need to resort to taking traditional medicine from Nigeria. Ola used the term '*not learned'* as someone who had not gone to school. I was already aware of the term having schooled in Nigeria as it was a common expression used to describe someone who was illiterate. I remember smiling with Ola when she said this. Having this shared understanding with Ola allowed her to express herself more fully, expanding on why she thought being educated was important in avoiding harmful cultural practices:

> *'If it is someone that is not learned that they use herbs and other things like that, if they could get someone to tell them we don't actually need those herbs those two things you're using is sufficient.'* (Ola, fourth baby)

Tope discussed how her own mother had joined her in the UK from Nigeria during her pregnancy and had wanted her to take traditional medicine:

> '*Maybe my mom would have forced me…I said no, we don't do that .We don't drink all this concoctions. I have been OK for eight months now, without any concoctions.'* (Tope, first baby)

A systematic review highlighted the use of traditional medicine for general pregnancy wellbeing being prevalent among African women even in the diaspora (Shewamene et al., 2017). Tope valued Western medicine over traditional Nigerian treatment but did admit that if she had been in Nigeria, she would have taken traditional medicine. In my reflective notes, I documented my understanding of the pressure faced by women in Nigeria to resort to taking traditional medicine because of the fear of something going wrong with the pregnancy and being blamed. In this aspect, I could relate to the predicament faced by women. The expression of *'sanitising women'* against adhering to cultural practices, was used by Ola, as she believed that unless a woman was specifically advised against taking traditional medicine she may continue to do so**.** Ola's response to the question do you think women will hide such practices?, was:

> *'..if they* (authorities) *should know about it, that is when they will say they want to prosecute the woman…Yeah, they will hide it.'* (Ola, fourth baby)

This highlighted the importance of healthcare professionals having cultural knowledge of harmful practices (Esegbona-Adeigbe, 2011). Midwives would be unable to advise against harmful practices, simply because women do not reveal them. However, if the midwife has knowledge of harmful practices undertaken in particular cultures, women can be warned and safeguarded during pregnancy.

Belief in God prioritised over culture

When mothers were asked about embracing cultural practices regarding pregnancy, God was mentioned by six mothers as being more significant than their culture, as reported by Ngozi:

> *'… I pray about my situation…and hand over to God, he takes control from there, so that's what I believe…I don't have any other views (*apart*) from being a Christian.'* (Ngozi, first baby)

Mothers discussed how their pregnancy was impacted by a condition that required treatment and how they coped with difficulties by their belief in God, this guided any choices they made during pregnancy. Tope discussed an interaction she had with a doctor when she had considered not continuing with her pregnancy due to ill health:

'*So, there was a particular doctor I spoke to her about that, she told me that what religion was I …I told her Christian. So, she assured me that, you know, you're not supposed to, as a Christian, you are not supposed to do this.'* (Tope, first baby)

Ola was diagnosed with a medical condition just before discovering she was pregnant and discussed how she had to deal with being in a new country, newly pregnant and undergoing treatment. She discussed how her belief in God helped her to cope with her diagnosis:

'If I didn't move here, I know my purpose here. At that moment, I know God said it is not work. That is the first thing for you… your health is important.' (Ola, fourth baby)

Reflection

I reflected on my interview with Ola, and noted her positive demeanor, laughing even when discussing her diagnosis and having to decide if she would continue her pregnancy. My thoughts were that she was very brave. Her trust in God was very evident and I could understand her perspective. However, I imagined the stress she would have gone through, being a mother to three other children and having to deal with a medical condition whilst pregnant. I saw her as a survivor, and I admired her.

Ozioma described how dealing with being pregnant in a new country was overwhelming and how she coped with being far away from family and friends by putting her trust in God and her husband:

'I talk to my God and my husband.' (Ozioma, first baby)

In relation to whether culture had an influence on their health seeking behaviour, Tope spoke about how God rather than culture guided her decisions during pregnancy:

'…I pray about my situation and…hand over to God, He takes control from there, so that's what I believe.' (Tope, first baby)

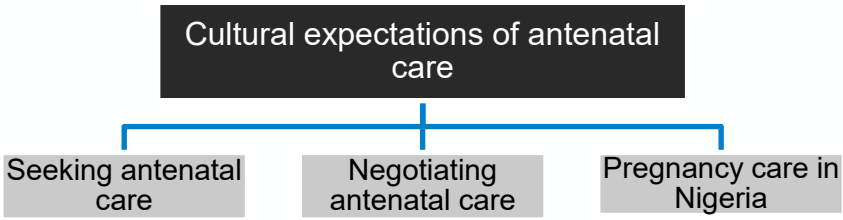
Ife also discussed the importance of having her religion respected more than her culture as she derived a great amount of strength from her beliefs:

> *'But if it has to do with maybe religion… I want them to respect that, I mean that's just my foundation.'* (Ife, third baby)

The mothers articulated how their religion assisted in overcoming a multitude of issues during their pregnancy, rather than their culture.

5.3 Theme 3: Cultural expectations of antenatal care

> *'…differences I can point out now that is the person centred approach here in the UK compared to Nigeria where you have to go in a group for the clinic but here…it was one-to - one* (care*).'*



Mothers had different expectations regarding their pregnancy care in the UK. Six mothers had delivered babies in Nigeria and six mothers were already pregnant when they arrived in the UK, so they had experience of antenatal care in both countries. Mother's cultural expectations of antenatal care were formed from previous experiences or knowledge of how care was provided in Nigeria.

Seeking antenatal care

Some mothers stated it would have been useful to discuss their experiences in accessing care with the midwife but the opportunity to do so was limited. Mothers told various stories about how they accessed antenatal care and the unexpected issues they encountered. Bola recounted how she

kept calling the hospital to get an appointment and was unable to comprehend why her pregnancy was not deemed to be important enough to be seen immediately. This would not have been the case in Nigeria, where women could walk into a maternity unit and be seen by a doctor or a midwife. Bola discussed her difficulties and frustration of being turned away when she attended a maternity unit in the UK after waiting weeks for an appointment:

> *'I don't know, I called at the hospital, I registered they told me they can't attend to me until they have seen my name on the system …from February, I was given the next appointment in March I feel it* (was) *too far.'* (Bola, first baby)

Bola stated that she was not asked why she had booked after 12 weeks for antenatal care, she stated by that time she did not want to discuss the issue further as the experience had been upsetting. The frustration felt by Bola was heard in her voice, it appeared that this had a negative impact on the start of her pregnancy care.

Yinka and Tope reported their experiences of accessing antenatal care:

> *'… immediately that I arrived, I went to the GP to register. I made him understand that I'm pregnant and all that… and I would appreciate if they can start off with my antenatal and all of that…I was waiting weeks until one month, I didn't get a call. Nothing.'* (Yinka, first baby)

> *'I went to an NHS site. Do you understand? But I didn't get an appointment to the GP immediately. I had to keep… to keep calling, calling, and calling because you know, they try to register with your local GP. I kept calling that particular GP for a while before they answered me because they were the one that referred me.'* (Tope, first baby)

Mothers were dissatisfied that antenatal care was not as accessible as anticipated. One mother who had to travel a long distance to get to her initial appointment and arrived late, '*pleaded to be seen,'* and she was surprised to be turned away. This mother discussed how this was upsetting and could not understand why her need for pregnancy care was belittled. This was something that she stated would not have occurred in Nigeria. Some mothers did not encounter any problems accessing antenatal care and were satisfied with how the health care service catered to their needs. Tola did not realise she was pregnant with her first baby when she arrived in the UK, she started bleeding and was advised by a friend to attend the Accident and Emergency department. It was here that she was informed how to access antenatal care. Chineke explained how the process

was simple after contacting her GP, she was given an antenatal booking appointment. Other mothers reported how they accessed antenatal care despite some initial challenges as reported by Temi:

> *'So, when I first arrived… we arrived here to do a job that my husband got, so I think for the first month we were still in the hotel that that they gave…so we hadn't like gotten our own place yet. We moved to a house…so it was then we were able to register for the medical care.'* (Temi, first baby)

A few mothers did not experience any issues with accessing antenatal care. Yemi, who was a student on a health care course when she became pregnant with her fourth baby, stated that she benefited from her knowledge of the UK healthcare system. Lola and Abi recounted their experiences:

> *'It was straight forward, I sent a message to my GP, and they sent me the list of hospitals, and I sent a message to the hospital.'* (Lola, second baby)

> *'Yes… I went to my GP first then the GP booked me with the midwife…It wasn't long at all… it wasn't even up to a week before they* (gave) *the appt.'* (Abi, third baby)

Therefore, knowledge on how the UK healthcare system operated was useful in navigating and accessing maternity care. However, mothers generally reported how complex it could be trying to engage with a healthcare service in a new country. Mothers indicated that midwives should be aware of the difficulties that newly arrived migrant women may have when accessing antenatal care.

Negotiating antenatal care

Mothers revealed the difficulties and complexities that they experienced once they had booked for antenatal care. Conditions such as pregnancy induced hypertension and gestational diabetes were reported by mothers, meaning that they had to have additional care included within their routine antenatal care. Understanding advice regarding diet and exercise were generally not raised as issues by mothers. Most mothers stated that they had no issues with their antenatal care once they

had booked: '*good experiences of antenatal care,'* '*given choice,'* '*making sure you are fine,'* '*it was very good.'* Chineke described her experiences:

> *' When I was going to antenatal everything was nice. (The) lady was nice. Everybody was nice.'* (Chineke, first baby)

Mothers articulated how their expectations were met and in some cases they were surprised about how organised and detailed their antenatal care was. This was the same with mothers who had experienced antenatal care in both Nigeria and the UK:

> *'…differences I can point out now… is the person centred approach here in the UK compared to Nigeria where you have to go in a group for the clinic but here…it was one-to-one.'* (Lola, second baby)

> *'I was asked so many questions (laugh) …Yeah…It was an experience because …on getting home I was like wow...I was actually going for a drilling.'* (Yinka, first baby)

> *'..because follow up for antenatal here is very well organised… like when they see something coming they want to tackle it before you are affected or before the baby is affected. Rather than in Nigeria where they don't even know… sorry to say that.'* (Abi, third baby*)*

Many of the mothers had no issues in attending for their antenatal appointments and mainly expressed no concerns around the number of appointments they had to attend. However, there was one women who talked about how she did not have time to discuss any concerns with the midwife because of the short time allocated for her appointments. Ozioma stated that it was being told by the midwife '*OK we are done,'* which took away her desire to ask any questions about her health or her baby's wellbeing. She reported that after waiting for so long she did not want to discuss any queries she had with the midwife stating, *'Most times I get in there angry.'* Ozioma offered a further explanation of how waiting for lengthy periods affected her:

> *' Yeah and most of the time as a pregnant woman … well let me speak for myself … I feel dizzy sitting in a particular place for quite a long time. So, when I get there I wouldn't want to waste much of my time.'* (Ozioma, first baby)

Ife also expressed surprise about the length of time she had to wait to see the midwife:

> *'So, I don't know if it's because they don't have enough staff, or it's just the system they want to upgrade. I spent a lot of time waiting and waiting.'* (Ife, third baby)

It was also communicated by another mother that her care was not of a good standard. Temi stated that she had been diagnosed with gestational diabetes after being told that her screening test was normal and described how this had been demoralising. Temi stated, '*I was broken,'* and she described a loss of confidence in the maternity services after this experience. The mothers' narratives revealed that more time needed to be spent during antenatal consultations in order to meet their needs. Mothers valued the time spent with midwives but felt that they were unaware of the importance of having these interactions for women.

Pregnancy care in Nigeria

Mothers discussed how their experiences or knowledge on pregnancy care in Nigeria positively shaped their opinions of healthcare in the UK. The infrastructure of healthcare in Nigeria meant that women could choose where to attend for antenatal care. The mothers who had experienced antenatal care in Nigeria talked about the stark differences compared to the care received in the UK. A mother discussed having weekly checks with the midwife in Nigeria, and the level of information she received in comparison to the UK:

> *'…in Nigeria there are lots of activities that a midwife do* (to) *engage pregnant mum*(s), *like they help them do exercise, teach them lots of things like that. I was actually expecting it here, but it was totally different … which is still fine by me.'* (Ozioma, first baby)

Another mother reported not seeing the midwife at all in Nigeria, only doctors which she discovered was vastly different to the UK, where she only saw midwives for her antenatal care. This fact was supported by other mothers as it was explained that when attending care in a private hospital in Nigeria you would see a doctor, and in government-funded hospitals care was provided by midwives. The provision of information and support offered in Nigeria was spoken of by several mothers. Temi discussed what she had heard about antenatal care in Nigeria*:*

'They give them a talk, they show them things, how to take care of the baby…they sing and dance together, they have like communities.' (Temi, first baby)

Yinka reminisced on how easy seeking medical advice and treatment had been in Nigeria:

'Most times I get feedback … immediately. But back here, they keep booking you… if maybe that I have to run a scan, they book an appointment for a scan…they book an appt for a midwife… a different appt for doctor…that was one of the first culture shock, that I experienced.' (Yinka, first baby)

Ife expanded further on access to medical care, having had children in Nigeria she was able to discuss how antenatal care compared to the UK:

'… you quickly have access to (the) *pharmacy, you can call up the doctor, doctor will say oh go and get this, from his experience or her experience. You know, but here you have to see the GP before … so you have to request a prescription online you know. So, yeah over here the GP cannot just say oh go to the pharmacist and get this.'* (Ife, third baby)

The issue of not being treated well in Nigeria during pregnancy care, was raised by several mothers, this was either from their own personal experiences or from stories that they had heard from friends and family. Mothers reported: '*it's all pain and stress,'* and '*I had a bad experience.'* Several mothers provided stories of maternal deaths in Nigeria and how it was common knowledge that childbirth was a perilous time: '*I lost a friend, the baby was OK, but she died*,' '*women die in childbirth….due to negligence.'* Mothers reflected on the attention of midwives in the UK to ensuring that permission was always sought during antenatal care, which was in stark contrast to care in Nigeria. Three mothers described the standard of maternity care in Nigeria:

' *Yeah, they don't mind, they just do anyhow they want to… without your permission they can do anything, they don't even need your permission to do anything.'* (Ozioma, first baby)

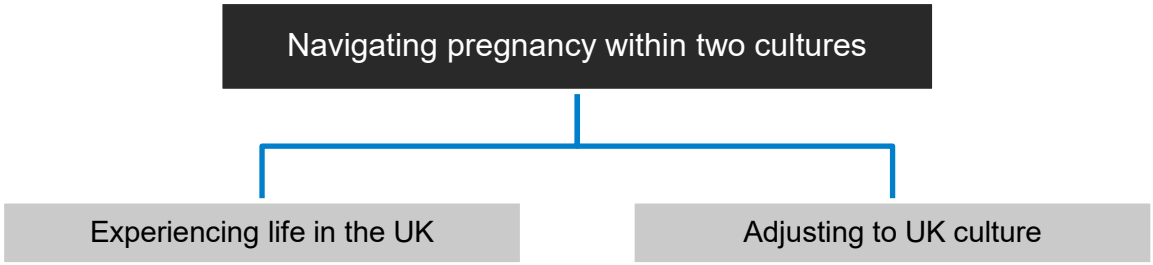
'I have heard people saying that the nurse(s) are very rude to them and not welcoming like I described the midwives that I had, and it's not just one person that says that it's like general knowledge...' (Toyin, first baby)

'Back in Nigeria the nurses ... some of them are a bit hostile, they are not really accommodating like the nurses here.' (Amaka, second baby)

The mothers' discussion around childbirth experiences in Nigeria was mainly negative, a few mothers reported positive experiences around access to healthcare services and advice. It was noted that mothers stated nurses rather than midwives when discussing maternity care in Nigeria, further revealing the differences to maternity care provision in the UK. Ultimately, mothers reported that they believed that antenatal care was more conducive to their needs in the UK. Showing that they were satisfied with the quality of care in the UK, regardless of their cultural needs.

5.4 Theme 4: Navigating pregnancy within two cultures

'I didn't have a whole lot of expectations…when I came in there… I just allowed things to flow and watch things go.'



Acculturation occurred differently for the mothers, and this was not dependent on duration of time in the UK. Challenges were faced by most mothers who had to adapt to life in the UK and being pregnant. Mothers were required to make choices based on a range of factors. Ultimately, mothers negotiated their cultural needs according to their circumstances, so this varied throughout pregnancy.

Experiencing life in the UK

Cultural skill involves being empathetic to different cultures and an ability for healthcare professionals to adjust health assessments and advice to the individual (Campinha-Bacote, 2002; Stubbe, 2020). There was sparse information from mothers that midwives discussed how they had adapted to living in the UK. Mothers revealed surprise from seeing so many people who were from the same race as them in London but were aware that this was not the case in other parts of the UK:

> *'Let me say that, but in this side of England, we do have quite a lot of Black people.'* (Toyin, first baby*)*

Learning to adapt and being prepared for anything after migration to the UK were verbalised differently by mothers, as discussed by Yinka and Abi:

> *'I didn't have a whole lot of expectations…because I understand that, yeah, I am in a new environment …so … I just allowed things to flow and watch things go.'* (Yinka, first baby)

> *'Yes, I understand the healthcare service and I am trying to adapt gradually, gradually, gradually.'* (Abi, third baby)

Abi had been in the UK over two years longer than Yinka and the feelings of adjusting to life in the UK were similar. When asked about the differences of living in the UK, Abi declined to speak further about this aspect, it was unclear of why this direction of questions was abandoned. Other mothers were willing to discuss differences further when asked. One mother explained how she believed that White people did not show their dislike for Black people, and this was something that had to be dealt with and inevitable when living in the UK. Ola explained her experiences of being a Black migrant in the UK and her perceptions of White individuals:

' …they won't show you… even if they do not like you…but from what I've studied about them; they will still go along with you. They will speak along with you.' (Ola, fourth baby)

Reflection

My reflective notes from this interview acknowledged that this may only have been revealed by mothers as they identified with me being a Black woman. This was not the first time I had come across this view in my personal and professional life. I believed these were beliefs that were easier discussed with individuals who share the same background. My position was that I could not deny someone perceptions of feeling that they were treated differently because they were Black.

This perception of Black people being disliked in the UK was only discussed by a few mothers. It was reported by most mothers that midwives remained professional during their antenatal care regardless of their race. Mothers valued this aspect of their care.

Mothers stated how the pace of life and systems were different in the UK compared to Nigeria. Lola described her first impression of living in the UK:

'*…I don't know maybe its London, everyone's busy, busy, busy.'* (Lola, second baby)

In Nigeria, the pace of life was slower, therefore mothers revealing that in the UK people appeared to be in a hurry, may have translated to a feeling that everyone was focused on their own lives. Mothers had begun to adapt to this faster pace of life, but these differences took some adjustments. Other difficulties were reported by mothers regarding living in the UK, everything was different such as transport, shopping, schooling, and housing. Amaka narrated how she had struggled to adjust to living in the UK:

'Yeah, it takes time to settle when you come to a new place because obviously if you're here for a long time, you kind of know the system but when you don't know the system and you're coming in new it can be a little bit difficult.' (Amaka, second baby)

Other mothers discussed issues related to work, travelling long distances to appointments, studying and being pregnant and difficulties in finding affordable housing. During the interviews, I noted the multitude of differences that mothers reported which they accepted as being part of their migration experience. However, mothers had limited discussion with midwives on how this impacted on their pregnancy care which they indicated would have been useful.

Adjusting to UK culture

Mothers discussed how they became aware of UK cultural norms and how they adjusted to living in a different culture. One mother said she searched on Google and was given advice about UK cultural norms by her husband who had migrated to the UK before her. These were norms such as how to greet people and how to address people, which were deemed to be important rules to understand quickly so as not to inadvertently cause offence. Mothers did not state that they had any particular difficulty with any aspects of UK culture. My reflective notes recorded that the use of the internet may have prepared mothers for any differences, but how the reality compared to the information retrieved was difficult to decipher from mother's responses. Mothers were reassured from having a lot of contact with healthcare professionals of a similar race. Mother's appreciated that differences in UK culture and Nigerian culture were discussed by midwives. It was identified during their antenatal care that some midwives were from Africa or that they were Black, and this facilitated the discussion of certain cultural practices such as FGM and male circumcision. Some mothers were unaware that there were laws prohibiting FGM in the UK, but that male circumcision was practiced. Another mother discussed how she was informed by the midwife that smoking in public was usual practice and was advised to avoid passive smoking which she had not been aware of. This mother was very surprised to know that she could be affected by breathing in smoke, as it was not health advice that she had heard in Nigeria.

Tope commented on how well she was treated as a single mother, as in Nigeria being pregnant and unmarried was not socially accepted:

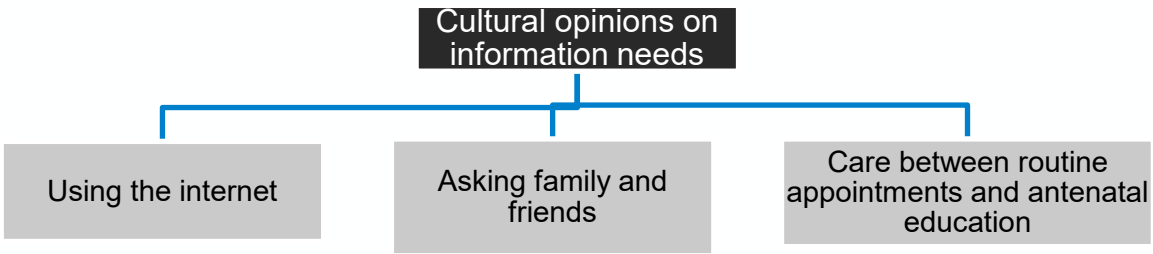
'They don't care whether… you are not married; you are having a baby. You know what I am trying to say, all they care about is your health and your baby's health.' (Tope, first baby)

The culture of a single mother being an unacceptable status, was another observation that I realised could impact on mother's pregnancy experiences. I understood from Tope's statement, that this had been a worry when she discovered she was pregnant, highlighting another possible cultural barrier to engagement with antenatal care that midwives should be aware of. Tope was pleased with how she was not judged and that her position as a single mother did not affect the quality of care she received. This encouraged her to express any concerns to midwives and made her feel that she was being treated the same as every other woman.

The English way of speaking was discussed differently by mothers. Tope used the term *'sugar coating,'* to describe the way people talk in Nigeria. On questioning Tope further, it was reported that *'sugar coating,'* meant making something sound achievable when in fact this was not the truth. Tope expressed that this was a common occurrence in Nigeria, particularly in healthcare settings and she was appreciative that this was not the case in the UK. The open dialogue between mothers and midwives was disclosed as being unusual and how they had to adapt to this, as healthcare interactions in Nigeria were very formal, with healthcare advice usually being accepted without any opposition. Therefore, some mothers felt unable to probe their midwives and ask further questions as it was not their usual practice. Healthcare professionals were seen as authoritarian figures in Nigeria and adjusting to the UK practice of questioning this authority was something mothers had to tackle. The different views of UK culture discussed by mothers highlighted how common practices may appear strange and bewildering to a new migrant. Mothers did not explicitly reveal if they had adjusted well to UK culture and appeared to accept differences without question as part of being a new migrant.

5.5 Theme 5: Cultural opinions on information needs

> *'First the internet and secondly there are some of the doctors in Nigeria that I was communicating with, and I talked with my mum.'*



Mothers sought information from various resources between antenatal appointments either due to requiring further health information or out of curiosity. One aspect of cultural competency is to disseminate healthcare information at the appropriate level for the individual (Ingram, 2012). Mothers' choices on where to seek health advice were influenced by various factors, such as availability of support networks or internet access.

Using the internet

Seven mothers discussed how they utilised the internet during their pregnancies for information. *'Google,'* and *'downloading,'* were mentioned several times during the interviews. Mothers articulated that they utilised the internet if there was '*something I am curious about,'* '*I had a feeling,'* or '*more I need to know about.'* Fourteen of the mothers had been educated to university level and commonly the need to seek further knowledge was to build up on information provided by the midwife. Ngozi stated how she utilised the internet to seek information:

> *'… like I said most times, I usually educate myself on the Internet, to know more and know how to navigate about.'* (Ngozi, first baby)

Yinka discussed how she wanted to understand postnatal depression as she knew there was something about feeling low after birth but was not informed about this by the midwife:

> *'I wasn't told but… I have gotten information… online about it*.' (Yinka, first baby)

Mothers disclosed that the use of the internet was useful for checking pregnancy practices that had not been addressed by midwives. It was indicated that mothers used the internet to be reassured about their well-being between antenatal appointments. Information was also sought online by mothers for their own personal interest as this was their usual practice or to explore any health symptoms. Chineke discussed how she used the internet to seek further detail on what she had been told by her midwife:

> *' 'I…use my phone to research how the woman goes on labour … and all that.'* (Chineke, first baby)

Abi used the internet for reassurance, and to check information the midwife had provided to her. It was indicated by mothers that despite the advice offered by midwives during their antenatal checks their information needs were not totally met. However, this was not limited to their cultural needs but their overall general needs around pregnancy well-being.

Asking family and friends

Mothers' narratives suggested that the midwife paying attention to their pregnancy needs and offering culturally specific information would have been useful. Eight mothers discussed how family and friends were used as a source of information. This was mainly in relation to health concerns due to the amount of time between antenatal appointments. Often contact was made with family in Nigeria due to mothers being new in the UK and not having a network of friends or family. Thirteen of the mothers were married, however one woman's husband was still in Nigeria. Therefore, information would also be sought from the husband, as explained by Ngozi:

> *'My husband … most times he was reading, and he was passing information to me as well.'* (Ngozi, first baby)

However, mothers reported some cultural restrictions in sharing pregnancy conditions with the husband as pregnancy was deemed to be a woman's domain. Women's mothers were frequently referred to as the person who provided advice about pregnancy. Information was sought mainly about what food to eat during pregnancy as one of the topics that arose with mothers during interviews was that the dietary advice given by midwives was difficult to follow. Amaka discussed how it was useful to have someone to discuss her cultural needs with:

> *'My mum told me a lot. You know just from my mum, not from the hospital.'* (Amaka, second baby)

Temi discussed how she was feeling unwell and was unable to get a satisfactory response from her midwife about her symptoms after a few appointments and eventually called a family member in Nigeria:

> *'I've also spoken to a cousin of mine back in Nigeria who has had a baby before, and she was 'Oh that's heartburn' – it happened to her.'* (Temi, first baby)

When Temi was questioned further on whether seeking advice from family members was beneficial her reply was:

> *'…every one's pregnancy journey is different…and really because of my cousin and having a good relationship with her I would say that I was able to …really talk to her about how I was feeling, really open up to family … so yeah, being able to talk to her was just reassuring,'* (Temi, first baby*)*

Mothers' views showed that they relied mainly on other avenues for information when the midwife did not provide this. However, mothers revealed that there was some reassurance from seeking information from family members. I noted that this behavior would have been a common practice for all women during pregnancy. The differences for these migrant mothers was seeking advice from relatives in Nigeria due to not having a support system in the UK. Therefore, pregnancy information may have been based on non-UK perspectives, leading to possible conflict with health advice offered in the UK by the midwife.

Care between routine appointments and antenatal education

Triage is not a common feature of maternity care in Nigeria; therefore, midwives being aware that women who are transferring care from one maternity system to another would have been useful. Mothers reported that these differences should have been explained by midwives as being a new migrant this was not something they would have known. However, some mothers knew that they could seek health advice from the GP or health visitor or attend the hospital triage to see a midwife, between antenatal appointments. In contrast, Tola mentioned that she did not know she could go to the hospital to see a midwife until she was further on in her pregnancy:

> *' OK, I think the point during my pregnancy I was always calling the GP. I didn't know I could call the triage. It was during that conversation that we just talk, talk, talk, OK, there's an emergency number for mental health. There's an emergency number for triage , so I had to ask what's triage for them to explain to me.'* (Tola, first baby)

One mother was very complimentary about the midwife signposting her to a pregnancy APP, as this allowed her to have more autonomy about her information needs. Tope reported that the midwife's advice could not cater for all her concerns:

> *'… the reverse was the case for mine when people were having the third trimester symptoms me I had it from the first trimester. You understand every pregnancy is different… So, the APP actually helped me a lot I won't lie.'* (Tope, first baby)

Mothers became aware during the later stages of their pregnancy or after the birth that information could have been retrieved from antenatal classes. Many mothers reported that antenatal classes would have been a particularly useful source of information as often advice sought from other sources could not be verified. In addition, mothers were unsure if cultural advice provided by family and friends was appropriate in the UK. This left mothers feeling unprepared for labour and parenting, especially as a first-time mother in a new country, as discussed by Bola:

> *''That is another thing I would like to complain of… when I gave birth the midwife was asking me to do some things …or saying some things about baby …then she realised I didn't go for any antenatal class…then she said did you not go for antenatal class …I said I did not coz I did not know...'* (Bola, first baby)

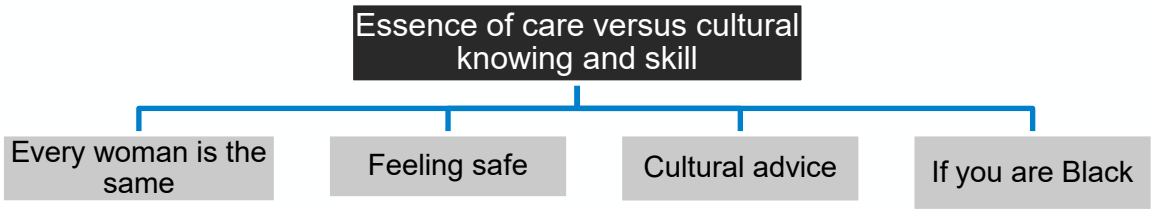
Several mothers lamented on the lost opportunity to attend antenatal classes. Mothers' responses such as: '*I wasn't told*,*' 'I wasn't offered*,' '*honestly I don't know why I missed the antenatal classes,'* demonstrated disappointment in this lack of information from midwives. Tola, who was having her first baby, stated that it was a person from her church who told her about the classes and by the time she enquired with the midwife it was too late, '*I feel that I missed out.'* This feeling was similar to Temi who was also having her first baby in the UK and had heard that In Nigeria, mothers sang and danced together during antenatal classes:

> *'… I don't even have any opportunity to speak to any women that would have been pregnant at the same time that I was, I didn't really have a community life with colleagues… for pregnancy*.' (Temi, first baby)

I noted the feelings displayed by mothers who told me that they had not been offered antenatal classes and having to console them during the interviews.

5.6 Theme 6. Essence of care versus cultural knowing and skill

> *' I believe* …(midwives') *experience, looking after African or Nigerian women doesn't really matter… to me I believe that every woman is the same yeah.'*



One factor needed to achieve cultural competency is cultural knowledge, which provides a platform for sharing and giving information in a culturally sensitive way (Esegbona-Adeigbe, 2011;

Papadopoulos, 2006). Mothers' perspectives on the importance of the midwife having cultural knowledge were explored. The impact of cultural knowledge on the quality of their antenatal care was discussed with mothers. Understanding the interactions between mothers and midwives was important to have a clear understanding of the mothers' perspectives on midwives' cultural knowledge.

Every woman is the same

Mothers were asked about the importance of the midwife having cultural knowledge and awareness during antenatal care. Five mothers expressed that they did not believe it was important. Mothers relayed this in several ways using words such as: '*it's not important,'* and '*the important thing is getting the appropriate or the necessary care.'* An explanation given by one mother who had three babies in Nigeria was that even if we are from the same country '*childbirth can't be the same … baby differs.'* Several first-time mothers had other responses:

> *'…it would be nice to know that she has taken care of someone from Nigeria. Then she probably would have some form of experience with maybe some cultural things… about*

some practices in Nigeria.' (Temi, first baby)

'Yeah…it would have because I would say the person would be able to relate more to where I'm coming from. If you get me.' (Toyin, first baby)

'(it) *would be an additional advantage for every midwife to know…of some information about where the person is coming* (from) *and all of that.'* (Yinka, first baby)

One mother stated that the midwife could '*not be faulted,'* for not knowing about different cultures as there are so many diverse communities in the UK, which made it difficult to know everything. However, this mother, who was a healthcare professional, felt that if you were working in healthcare in the UK you should try to learn about other cultures. Other mothers revealed that the midwives having more cultural knowledge would have increased the quality of their antenatal care. It was indicated that if cultural practices had been addressed routinely by the midwife during antenatal care this would have lessened mothers' anxiety. The mothers who had more dialogue with midwives who demonstrated cultural knowledge reported positive experiences.

Feeling safe

Some mothers discussed that feeling safe and having their values considered was particularly important during their antenatal care. This enabled them to converse more freely with the midwife. It was also explained by Amaka that the ability to make choices was more important than the midwife having cultural knowledge:

'It's not like they are imposing anything; they will always give you the avenue to choose.' (Amaka, second baby)

Chineke talked about valuing the advice provided by the midwife particularly as she was single and having her first baby. Her baby's father, although in the UK, lived far away, so the midwife was a resource that she utilised for support. Chineke expressed that the importance of staying healthy during pregnancy was due to being alone in the UK:

'I was so careful doing my best because I didn't want no complication because I know that I am just alone. If anything terrible, very serious happen(s) *to me...it's gonna be terrible...the only person that is so close to me is just my baby father.*' (Chineke, first baby)

Tola, who had her first baby in the UK divulged that even though the cultural knowledge of the midwife was not an essential element of her care, knowing that this experience was available meant: *'I would have felt safe.'* This was further supported by Ola, who stated that feeling safe meant she could be more open with the midwife. These narratives revealed that some mothers valued the midwives attention to their personal wellbeing over their cultural knowledge.

Cultural advice

Mothers were asked about any cultural advice offered by the midwife during their antenatal care, and if they felt this demonstrated experience of cultural encounters with other Black mothers. A mother disclosed discussing FGM with a midwife: '*So that means they would have had an experience of someone who has done that before.'* However, generally advice was not specific to the mother's culture concerning exercise and diet. One mother articulated that she was not given culturally specific dietary advice to manage her diabetes and was told to eat broccoli and stated, *'I had never heard of broccoli.'* This caused this mother some difficulty in trying to source the healthy diet advised by the midwife. Toyin had already divulged that she had no wishes regarding any cultural advice during her antenatal care. However, when discussing dietary advice, Toyin stated this would have been useful as she was not provided with culturally specific advice:

'...you know because we don't eat the same type of things in Nigeria…so it was just like general advice for the UK culture, it wasn't specific to my culture.' (Toyin, first baby)

A lack of midwives' adapting advice to the woman was not always the case as Amaka described how the midwife asked her about her diet and then adapted the dietary advice so that she understood what she could and could not eat which she found very useful:

'The (midwife) *that actually talked to me about the diet and all that, I think the (midwife) is from Nigeria also. If she's not from Nigeria I think she's African, but I know she's not a British.'* (Amaka, second baby)

Mothers reported that they received limited cultural advice from midwives during their antenatal care. Mothers' perceptions of receiving cultural advice was explored throughout each interview at least two to three times, as in interviews conducted early on in the data collection phase, it was found that mothers would remember something towards the end of the interview. It was disclosed that when cultural advice was a provided this was initiated by mothers and not the midwife.

***'If you are Black'* (Risk of Black ethnicity and pregnancy)**

Two mothers suggested that the midwife had some experience of looking after women from Africa as conversations during their antenatal care included the words: '*if you are Black,'* and '*because you are Black and in this country.'* One mother was unable to remember exactly what was said but seemed to think it was a warning about the risk of being pregnant as a Black women in the UK. These warnings from midwives mirrored findings from UK maternal mortality reports that highlighted the increased risk of maternal deaths for Black women (Knight et al., 2023). The mothers were unable to confirm during the interviews that they understood what the midwife was attempting to tell them. Abi struggled with trying to explain what the midwife meant**:**

> *'… because I am Black … may because you are Black, and you are in this country I don't know.'* (Abi, third baby)

I reflected that Abi had her third baby in the UK, her previous births had been in Nigeria where maternal deaths are known to be high, so the context of childbirth also being a risk in the UK may have been a surprise. The other mother was able to discuss this point of being warned by the midwife further, stating that the midwife mentioned this in relation to pain relief: '*Blacks don't want to take it.'* This mother remembered being told by the midwife the importance of accepting advice to ensure an optimum pregnancy outcome. However, it arose that this was mentioned during her delivery not during her antenatal care. Chineke discussed how she felt she was treated differently because she was Black and: '*not from this place*.' It was not indicated by mothers that they valued these warnings from midwives about being Black and pregnant in the UK and potential impact on their pregnancy. It was unclear if mothers understood that midwives were equipping them with this information to ensure that they had positive pregnancy outcomes.

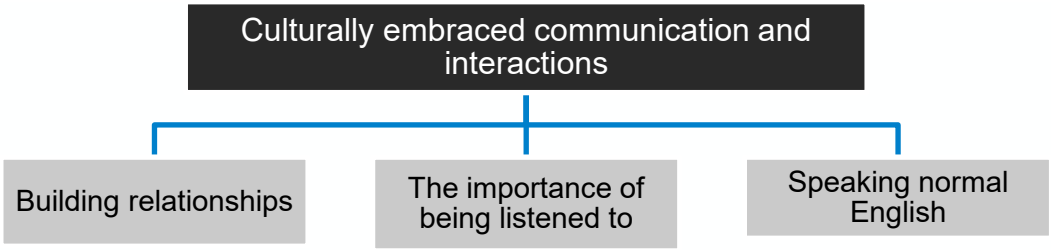
Reflection

I was initially surprised to hear from mothers that they were told in the course of their antenatal care that being Black and pregnant in the UK meant that they needed to be warned about potential issues. Although, in hindsight this should not have been the case as the focus groups with midwives had already alluded to the misconception of the 'strong Black woman' as being a cause of poorer pregnancy outcomes. My worry was how these mother may have felt when receiving this information from the midwife which I tried to explore further. However, this was limited as I was aware that I should be careful to not make the mother uncomfortable as this was not a pleasant topic to discuss when you have had a baby.

These narratives provided some insight into how ethnicity impacted on care provided to mothers and how maternal mortality reports influenced midwives' practice when caring for Black women.

5.7 Theme 7: Culturally embraced communication and interactions

'I saw about three different midwives … I was hoping that I was going to see the same midwife all the time…'



Communication and the interactions that mothers had with their midwives and whether their individual needs were met are discussed in this theme. Effective communication is a key component for safe midwifery care which has been highlighted in maternal mortality reports (Knight et al., 2023). A majority of the conversation around effective communication is around use of professional interpretation services for women who do not speak English or have a poor command of English (NHS, 2024). However, in this study all the mothers spoke English which should have reduced communication barriers.

Building relationships

Mothers appreciated the relationships they formed with midwives seeing this as a positive aspect of their antenatal care. One mother discussed how seeing different midwives for antenatal care was difficult for her and impacted on her ability to form a relationship and talked about '*continuity being broken.'* Ozioma had some expectations of antenatal care which she had commenced in Nigeria:

> *' … I learnt that once you find that you are pregnant here that you are being assigned a midwife, I don't really know how true this is , because … like I said, I actually saw a midwife at 24 weeks. The first time I saw the midwife … after the appointment there was nothing more. The second time I got to see a midwife it was actually a different person, yeah. So, the relationship all ended immediately after this appointment, you understand.'* (Ozioma, first baby)

In contrast, Abi did have continuity of carer which made her antenatal care a more positive experience:

> *'Because I am so used to her and… you know she started with me, and we are doing the following up without… distraction …she already knows everything about me in every of my appointments. I just fall in love with her that's it.'* (Abi, third baby)

These narratives revealed the stark differences in mother's antenatal care experiences and the impact of continuity of care on effective communication. Mothers who had some continuity of carer,

were asked to describe why they had a good relationship with the midwife, several examples were given:

> *'I would say I was free to talk, and she was open …the first time I met her it was a really nice experience … I think I can still remember it was really nice ..she really* (was) *accommodating and welcoming.'* (Bola, first baby)

> *'Yes, I think I basically saw maybe two of them, I think two were regular…Yes, I was comfortable…Just the way they interact with me…free to ask any questions it was a kind of rapport'* (Lola, second baby)

Chineke had some care provided by a Nigerian midwife, but reported that shared ethnicity was not the reason why she had a good relationship:

> *'Yeah…it's not because I'm* (a) *Nigerian woman, it's just because she's a very friendly person. That is what …I notice.'* (Chineke, first baby)

However, other mothers did discuss how being cared for by an African midwife meant that they felt they were more able to relate to her.

> *'I saw a lady from an African country, (who) was consistent towards the end of my pregnancy, so I could ask her questions, I could relate with her.'* (Tope, first baby)

Generally, even with no continuity of carer, it was relayed by four mothers that it was important to get their questions answered as this fostered a good relationship with midwives. One mother explained that being asked specifically about how she was feeling allowed her to discuss any concerns she had which she found useful, as described by Tope:

> *'Sometimes you're just tired and you just want to see the baby out. So, I remember just a few times (MW) asking…are you tired are you OK. So, we usually talk about my feelings. Trust me, they do that a lot.'* (Tope, first baby)

These narratives highlighted the value of continuity of carer, but also the importance of mothers having positive interactions with midwives, despite limited contact during the course of their antenatal care.

The importance of being listened to

Five mothers stated that they valued midwives listening to their concerns during their antenatal appointments and were able to discuss any concerns they had. However, one mother mentioned how she was unable to communicate with the midwife about a symptom she was experiencing and used the words: *'I didn't feel heard,'* and felt there was a: '*communication gap*.' Subsequently, this mother was able to explain her symptoms to another midwife who understood what she meant and was able to provide advice. It was unclear if mothers viewed midwives as being more supportive due to having cultural awareness or just the fact that they were more caring and compassionate. Mothers appreciated being given time to talk and the midwife being approachable, but they did not state that this was a cultural expectation. Mothers reported that being encouraged to talk made them feel that they were being listened to, which made them feel reassured and relaxed. In contrast, one mother discussed that the midwife was the only person she could really speak to about how she was feeling and coping with pregnancy as her husband: '*being a man,'* did not understand. However, she felt there was no time to do this as the main focus of the antenatal check was checking the baby's heartbeat and: '*all the bits you need to check.'* Temi discussed how she had wanted to convey some pregnancy concerns to her midwife but had not been given the chance to do so on a few occasions:

> *'I would try to explain something, maybe she didn't get what I needed… but nothing major, it was just something that I noticed happening…maybe once or twice.'* (Temi, first baby)

Mothers perceived that midwives prioritised the physical aspects of the antenatal check rather than their mental or emotional wellbeing. Consequently, mothers felt that there were lost opportunities to discuss their concerns with midwives. These concerns may have been significant issues that may have required further investigation or escalation by the midwife.

'*Speaking normal English*'

Several mothers disclosed difficulties in understanding the English spoken during their antenatal appointments and communicating with the midwife. Mothers expressed that understanding the advice delivered by midwives was an important aspect of their antenatal care and was something

that should be a high priority. One mother articulated how the midwives did not speak: '*normal English,'* and used the expression: '*putting it under your tongue*.' This term was deemed to mean that the midwife did not use enough words to explain any findings or convey health advice. On further exploration during the interview this mother revealed that when she was tired or in a low mood, she would just keep quiet and behave like she was: '*deaf and dumb.'* Hence, communication was restricted and limited. The task of trying to decipher complex health issues was disclosed by this mother as frustrating. This mother who had an appointment with an obstetrician who was also from Nigeria stated: '*when I met him he spoke my English, I spoke once, and he understood me*.' This showed the contribution of having a shared culture to effective communication. Mothers reported instances when a midwife spoke to fast or did not come straight to the point, stating that often the meaning of what was being said was lost:

> *'…yeah, even the English they are speaking if you tell them to send message to you now, you wouldn't be able to read it. You will be the one filling the gap.'* (Ola, fourth baby)

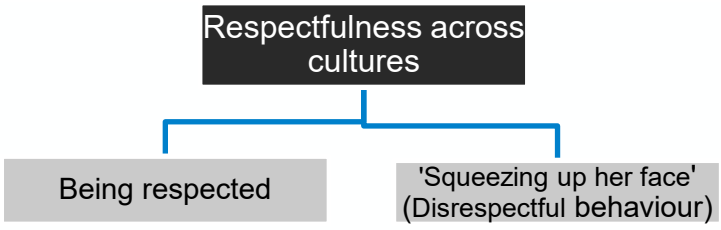
These cultural differences in language were evident in the narratives from women, even though they all spoke English. My reflective notes documented that this was not a surprise, as I had heard this view from family and friends, of not understanding health information despite being fluent in English. Furthermore, phrases or idioms used are not easily understood when English is spoken as a second language, let alone medical terminology. This would have been frustrating for mothers who were often disadvantaged by speaking English as it was reported that conversations were rushed during their consultations or time was not created to allow sufficient dialogue to check their understanding of medical advice.

Reflection

Due to having lived in both Nigeria and the UK and working in the USA for almost two years, I could empathise with mothers regarding their difficulties in understanding English. A good command of English, meant understanding local terms, nuances and expressions. I had faced similar issues of not understanding the American way of speaking English, whilst working as a nurse in the USA, a cot was called a crib, a dummy was called a pacifier and to vomit meant to barf. These were not complex medical terms but showed how the English language can be difficult to express or understand even with being proficient. I knew that the way English was spoken in Nigeria was different to the way it was spoken in the UK. English spoken in Nigeria is expressed differently with more measured and lengthier explanations. Therefore, understanding layperson's English may have posed difficulties for some mothers, let alone professional and medical terminology.

5.8 Theme 8: Respectfulness across cultures

> *'I really don't know to be honest (*Laughter*)… Because I do just know respect and disrespect when I see it.'*



Respect varies across diverse cultures and a lack of cultural awareness, sensitivity and knowledge can lead to inadvertently showing disrespect during health care provision. Culture shapes the development of personal values and their expression (Sagiv & Schwartz, 2022). Respect across

cultures can be communicated verbally, non-verbally or with appropriate use of intonation or pace of speech (MacKenzie & Wallace, 2011). Therefore, it was important to explore mothers' values regarding respect to see if this differed to UK norms. This theme provides a window into the mothers' perception of respect during their antenatal care and how this impacted on their pregnancy experiences.

Being respected

Signs of respect which were reported by mothers appeared to be similar to any other woman's expectations when receiving antenatal care. Care and attention from the midwife and how they were treated were described by mothers as being an essential component of antenatal care. Abi reported her feelings of having no issues with midwives and being treated with care:

> *'Like ..being bossy like you know not attending to you very well… there was nothing as such, they show a lot of care and attention, they were good at what they did.'* (Abi, third baby)

Amaka, who had a previous baby in Nigeria described that healthcare professionals being hostile and unaccommodating were issues back home, but not something she had experienced in the UK:

> *'…the character or the attitude, here it's much better than Nigeria.'* (Amaka, second baby)

Mothers did not explicitly divulge that respect was an important aspect of care, but this was alluded to in the conversations around consent and having their permission sought. Overall mothers reported satisfaction with their antenatal care in this aspect. Showing respect towards other cultures may lead to compromising of clinical judgment in an attempt to meet individual's needs (Casey et al., 2022). Mothers did not disclose any conflicts with midwives regarding their antenatal care demonstrating that care was mainly focused on their needs.

***'Squeezing up her face'* (Disrespectful behaviour)**

None of the mothers reported signs of disrespect during their routine antenatal care. This was indicated by mothers as being a positive aspect. It was acknowledged by mothers that signs of disrespect may be different in their culture compared to the UK. Amaka discussed some differences:

> '*…but back there in Nigeria, if you pass an elderly person without greeting the person it's a sign of disrespect… but here it's not the same.'* (Amaka, second baby)

This statement emphasised how respect differs across cultures, courtesy was expected by mothers during their antenatal care, such as being asked how they were feeling generally before commencing the appointment. Another sign of disrespect that mothers discussed was: '*squeezing up her face.'* The term 'squeezing up her face,' I recognised as a term used by Black communities to describe someone who was frowning. Therefore, culturally unacceptable body language could be seen as a sign of disrespect. Furthermore, mothers discussed that inadequate explanations of care provided or needed was seen as being disrespected. Mothers' interpretations of disrespect has been reflected in numerous studies with women (Ishola et al., 2017; Oche et al., 2024; Orpin et al., 2014). Disrespectful maternity care was defined by Bowser and Hill (2010) after a landscape analysis, as physical abuse, non-consented, non-confidential care, non-dignified care, discrimination, abandonment of care and detention in facilities. None of the mothers reported signs of disrespect from midwives during their routine antenatal care. The mothers' narratives alluded to cultural perceptions of respect or disrespect and how the presence or absence of this would impact on their antenatal care experiences.

Reflection

My feelings were that some signs of disrespect transcends cultures. Showing anger through facial expressions and not seeking permission before providing care seemed to be obvious signs of disrespect. However, I was aware that some cultural norms in Nigeria such as not looking directly into the eyes of an older person or not asking after someone's family before communicating about other issues were not seen as disrespect in the UK. However, I did not direct mothers to discuss these norms, so as to not influence their answers.

5.9 Summary of findings

This study was conducted to explore migrant Nigerian mothers' and midwives' perceptions of cultural competency in antenatal care. The views of fifteen mothers have been provided in this chapter together with excerpts from a reflective journal. Accounts provided by the migrant Nigerian mothers showed how they navigated their pregnancy in a new country, dealt with transgressing the NHS, protected, or obscured cultural practices and perceived the role of midwives. The next chapter discusses and explores the findings from chapter 4 and this chapter, building on existing evidence and providing unique contributions to knowledge about Black African women's and midwives' perceptions of cultural competency in routine antenatal care in the UK.

Chapter 6: Discussion

Introduction

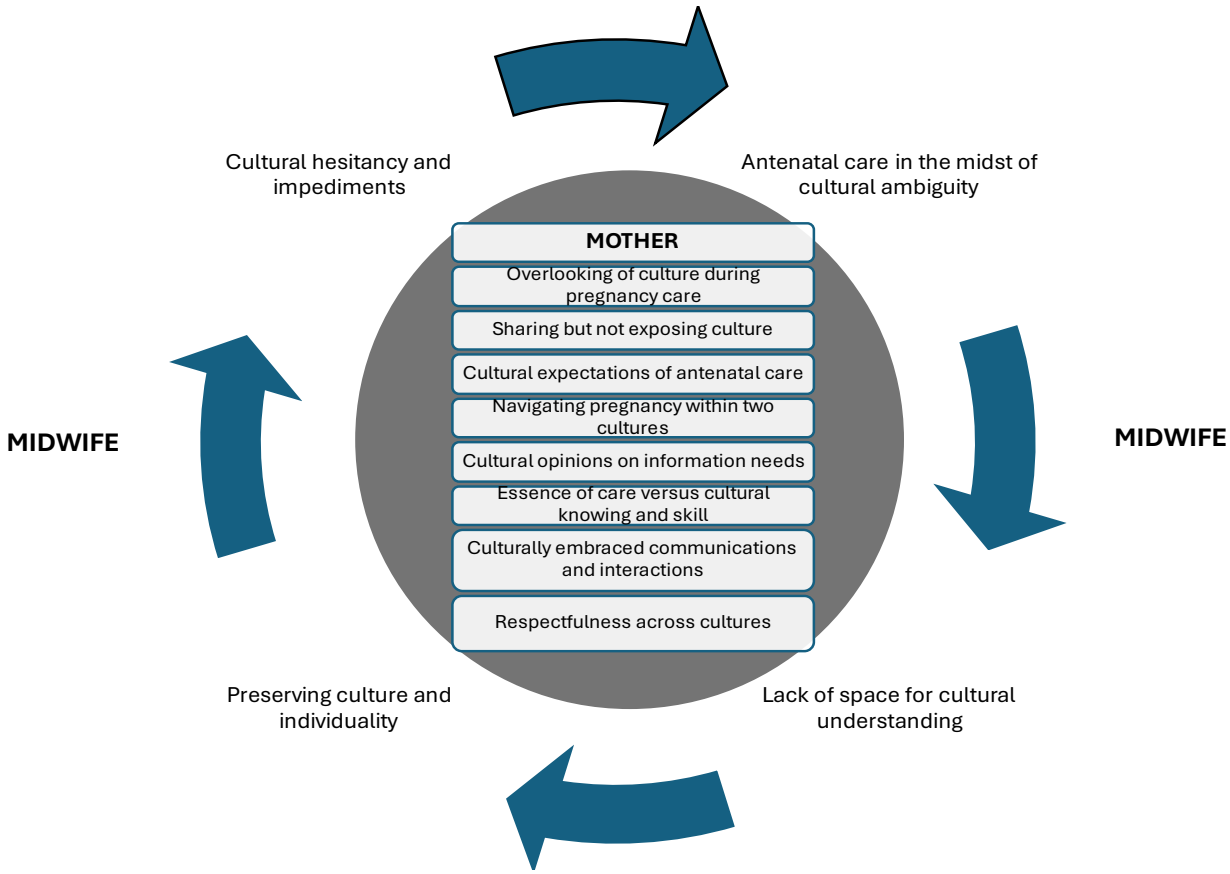
This chapter will discuss migrant Nigerian mothers' and midwives' perceptions of cultural competency in antenatal care with reference to the evidence. The underpinning purpose of this study was to add to the body of knowledge about migrant Black African women's and midwives' understanding of cultural competency in antenatal care. This issue has grown in importance due to maternal mortality reports stating that migrant Black African women have been a high-risk group since 2000, linked to little or no engagement with antenatal care which may be connected to cultural factors (Knight et al., 2023). However, insufficient attention has been paid to cultural influences in antenatal care attendance, the focus in this under researched area. Nigerian women were one of the prevalent groups featured regularly in maternal mortality reports (CEMACH, 2004; Knight et al., 2023), therefore they were the participants selected for this study. The research questions were, '*How do the perceptions of migrant Nigerian women differ from midwives' perceptions of cultural competency in antenatal care?'* and '*What are the cultural needs of migrant Nigerian women and how are their needs currently addressed within antenatal care provision in the NHS?* Focus groups in two Trusts, were conducted each consisting of four midwives who had experience of providing routine antenatal care. One-to-one interviews were undertaken with 15 Nigerian mothers who had been in the UK for less than five years and had delivered a baby within the last year at either Trust. A qualitative descriptive approach was utilised; data collection occurred over a period of 12 months and conventional content analysis was conducted.

Four overarching themes were revealed from the focus group discussions: (1) antenatal care in the midst of cultural ambiguity, (2) lack of space for cultural understanding, (3) preserving culture and individuality and (4) cultural hesitancy and impediments. The one-to-one interviews with the Nigerian women revealed a complex picture of their antenatal care experiences consisting of eight themes: (1) overlooking of culture during pregnancy care, (2) sharing but not exposing culture, (3) cultural expectations of antenatal care, (4) navigating pregnancy within two cultures, (5) cultural opinions on information needs, (6) essence of care versus cultural knowing and skill, (7) culturally embraced communication and interactions and (8) respectfulness across cultures (see figure 10 1). The data suggests that midwives are aware of the importance of culturally competent care but are constrained by societal, professional, and organisational factors.

The data supports that women are not routinely asked about their culture during their antenatal care, and mothers prioritised the physical needs of their pregnancy over their cultural needs. A conceptual framework assisted in organising this research study and provided a lens through which the findings could be viewed and explained (Varpio et al., 2020). This chapter provides an analysis of the derived themes using the concepts of cultural competency from Campinha-Bacote (2002) and Papadopoulos et al. (1998) to frame the discussion (see figure 11 1).

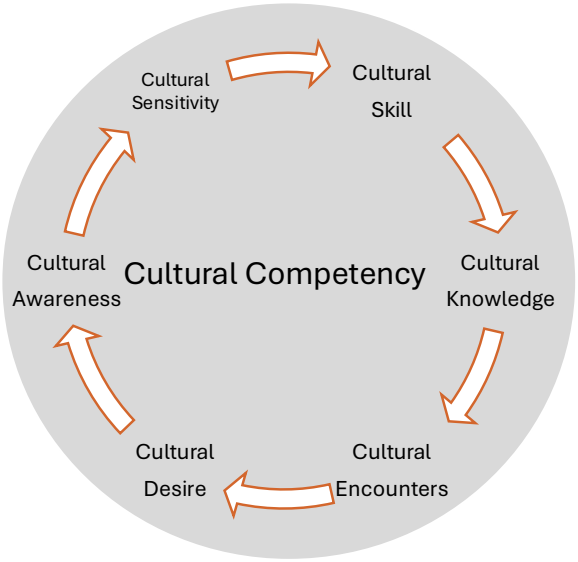
6.1 Themes

Figure 10 1: Themes from focus groups with midwives and interviews with mothers



6.2 Conceptual framework

Figure 11 1: Conceptual framework of cultural competency- Campinha- Bacote (2002) and Papadopoulos et al. (1998)



In seeking to investigate and analyse participants' perceptions of cultural competency it was useful to consider how this was constructed by mothers and midwives during this study. Therefore, the components of cultural competency: cultural awareness, cultural sensitivity, cultural skill, cultural knowledge, cultural encounters, and cultural desire are reviewed in relation to the research findings.

6.3 Cultural awareness and sensitivity

This study reveals how midwives perceive cultural awareness and which behaviours they adopted to demonstrate this. Midwives' cultural awareness was demonstrated by their acknowledgment of cultural differences and articulating the impact of unconscious bias, racism, discrimination, and stereotyping on quality of antenatal care provision. These are all attributes recognised as essential components for the development of cultural awareness (Papadopoulos, 2006). Both focus groups discussed their understanding of unconscious bias, and how it impacted on their daily clinical practice. This study shows that midwives accept that everyone has biases, which is a key skill in reducing unconscious bias when making actions and decisions in providing care (Hahn & Gawronski, 2019). Some midwives recognised that their unconscious bias was led by and impacted by external factors, such as personal and professional contact with other cultures and personal reflection of these experiences. Furthermore, midwives articulated the impact of increased workload and reduced staffing on their ability to be conscious of their biases. This study builds on the evidence from Meidert et al. (2023) who states that high cognitive load, and workload fatigue are known to impact healthcare professionals' ability to suppress their biases. Deliberate reflection can help individuals to recognise biases and adjust their behaviour (Marcelin et al., 2019). Opportunities for midwives to reflect on their biases were hindered by their workload, as space and time to undertake this activity was limited. Thereby, showing that any barriers to the ability to reflect can hamper the ability to recognise unconscious bias, leading to cultural unawareness and insensitivity. This study confirms that midwives' cultural awareness and sensitivity is limited by personal, professional, and organisational factors.

This study provides evidence that midwives recognise that cultural unawareness can lead to caring for women in a certain manner, which results in lack of cultural sensitivity, prejudgment, and prejudice. The narratives from this study showed that discrimination was present in current maternity care provision in the UK, building on the available evidence (Cross-Sudworth, 2007; Silverio et al., 2023; Vousden & Knight, 2024). The frequent use of the words 'race' and 'discrimination' by midwives highlighted that they linked adverse pregnancy outcomes for migrant women to racial inequalities. Lister et al. (2019) discussed racial bias as the 'elephant in the room' (p 1), stating that maternal deaths could be addressed by acknowledging differences and treating women with respect and compassion. The present study shows that midwives attempt to reduce racial disparities by being culturally aware and sensitive when providing care. However, this approach can lead to overzealous attempts to provide appropriate care (Henderson et al., 2013; Jomeen & Redshaw, 2013; Squire & Sookhoo, 2017), leading to stereotyping and causing offense

(Hall, 2024). Nevertheless, midwives understood the disadvantage of stereotyping women and anticipating them to behave in a particular way just because they were from a particular ethnic group. It was acknowledged that such assumptions led to insensitive care despite a midwife's attempt to respect a woman's culture.

Prejudgment, racism, and discrimination has been reported in other studies exploring maternity care experiences of Black migrant women (Bulman & McCourt, 2002; Fair et al., 2020; Higginbottom et al., 2019). Racism was unclear in its content and context in Bulman and McCourt's (2002) study which alluded to unequal access to health services. Overt discrimination was revealed by Higginbottom et al. (2019), stating women felt devalued, and were treated differently. In other studies, references to discrimination were more subtle with women reporting unfriendliness, feeling different and feeling disempowered when making decisions about their care (Degni et al., 2014, Mohale et al., 2017; Murray et al., 2010). In this study, midwives suggested that stereotyping, prejudgment, and discrimination could be mitigated by providing universal midwifery care for all women. This view is challenged by Lau (2016), who argues that to address racial disparities, going beyond universal care is required, however in contrast maternal mortality reports have advocated for individualised care (Knight et al., 2023).

Midwives when asked if they were aware of a woman's culture during antenatal care provision, very distinctly discussed how recognising differences was a precursor to discrimination. One midwife highlighted the fact that discrimination occurred not just between people of different races but there was interracial discrimination, a term coined as internalised racism (Cabiles, 2024).[9] MW 4, discussed that the care received by women was sub-standard due to interracial discrimination:

> *'…we've heard of that, in many reports, especially with…you know, the take five campaign, where women were being discriminated by the, you know, people from their own kind of races, not so much like an interracial like problem.'* (MW 4, qualified four years)

[9] Internalised racism-A belief about one's own inferiority as a function of membership in an oppressed group.

Discrimination being an issue between individuals of the same ethnic background has not been revealed in other studies. MBRRACE (Mothers and Babies Reducing Risk through Audits and Confidential Enquiries) (2022), compared the quality of care received by women from different ethnic groups, and found multiple areas of bias and microaggressions [10]. However, MBRRACE (2022) did not reveal the care provider's ethnicity for the women who died, showing a gap in the evidence. Midwives' acknowledgment of racism and discrimination in maternity services in this study and racism between individuals of the same ethnicity provides new insights into migrant women's pregnancy experiences.

Racism and discrimination were alluded to in both focus groups, but more directly in the meeting with midwives of only Black ethnicity. Indicating that sensitive topics are easily discussed when there is a shared identity, a perceived safe environment, and an open dialogue (Samardzic, 2023). In contrast, the mixed ethnicity focus group did not have a deep discussion about racism and discrimination. Furthermore, it was only the midwives of Black ethnicity in the mixed ethnicity focus group that raised the issue of discrimination, it was noted that the White midwives did not explicitly add to the conversation. This observation suggests the concept of White fragility, which states that it may be difficult for White people to talk about racism (Frey, 2020). The White midwives may have felt uncomfortable or insecure in discussing discrimination in the presence of Black midwives. These findings add to other studies where it is reported that White individuals have experienced vulnerability caused by racism and discrimination (Applebaum, 2021; Frey, 2020). Furthermore, these findings fit with the theory that White individuals have felt guilty, sad, exhausted and to drained to talk about racism and discrimination (Ford et al., 2022; Hill et al., 2021).

[10] Microaggressions-A statement, action or incident regarded as an instance of indirect discrimination against members of a racialised group or ethnic minority

Reflection

The concept of White fragility, bought to mind my dialogue with White colleagues and how difficult it may be for them to discuss issues around racism and discrimination. I recall one White colleague sharing her embarrassment about racist events in the past and how it made her ashamed that her ancestors were part of that history. In addition, I have had White colleagues discuss how the past is not our present and that racism does not occur. In hindsight, further exploration on racism and discrimination with the mixed ethnicity focus groups would have been beneficial.

Othering is a social process that goes beyond the concepts of discrimination by assuming that there are homogenous social groups with no individuality (Akbulut & Razum, 2022; Jensen, 2011). A skill required to facilitate cultural awareness is recognition that women are heterogenous (Hultsjo et al., 2019). In the present study, midwives showed awareness of the cultural differences in migrant women when providing antenatal care. This contrasted with findings from Shorey et al. (2021), who discussed cultural blindness, as a process of 'othering', whereby women from diverse cultures were seen by maternity care providers as one homogenous group. The danger of midwives not treating women as individuals with complex needs can lead to providing a package of care that is one size fits all. 'Othering' has been found in other studies with midwives, where all migrant women were seen as one homogenous group leading to stereotyping and care that was not individualised (Lyons et al., 2008; Tobin et al., 2014). However, the concept of 'othering' was not discovered in this study, which indicated that midwives did not perceive migrants as a homogenous group.

In the present study, conflict between the midwives' professional culture and their personal culture was seen in the narratives from the focus groups. The culture of the midwifery profession has norms and beliefs governed by the statutory framework of the NMC (NMC, 2018). The need to consider in effect, three cultures, the midwife's professional and personal culture and the woman's culture challenged midwives' ability to be culturally aware. The present study's findings build on Aquino et al's (2015) and Higginbottom et al's. (2019) studies, where conflict between midwives and Black and minority ethnic women on expectations of care adversely affected the woman-

midwife relationship. The NMC professional code of conduct stipulates how a midwife should act to maintain the integrity of the profession (NMC, 2018; NMC, 2021). The midwifery professional culture is adopted by individuals entering the profession created by training and teaching methods, which individuals adopt to become part of the profession (Arundell et al., 2018). This professional culture may be merged with the midwife's own personal culture, leading to an amalgamation of two cultures. This combination of two cultures was evident in the present study. It is alleged that healthcare professionals tend to lean towards ethnocentrism, meaning that they belief their professional culture is superior to other cultures (Jordal & Wahlberg, 2018; Markey et al., 2018). This superiority was not evident from the focus group discussions, but particular ways of performing or behaving in the workplace which had become an integral part of midwives' beliefs and attitudes was highlighted in this study. The workplace environment is stated to have an influence on midwives' professional culture (Davis & Homer, 2016). Importantly, the impact of professional culture can affect care provision, if health professionals fail to identify and legitimise the cultural identity of the women they care for (Phiri et al., 2010). Acknowledging their professional responsibilities was prioritised by midwives in this study, which made the process of being culturally aware complex.

The importance of not imposing their own culture on the woman was conveyed by midwives as this conflicted with their professional responsibility. Midwives accepted that imposing personal cultural views on women was similar to enforcing care. There were no expectations by midwives in this study for women to adapt to the dominant culture which contrasted with other studies with migrant Black African women (Lyons et al., 2008; Tobin et al., 2014). In other studies, healthcare professionals were frustrated by the need to care for migrant women and expected women to adapt to the dominant culture (Lyons et al., 2008; Tobin et al., 2014). Such expectations has been stated to lead to cultural destructiveness[11] (Shorey et al. 2021). Midwives in the present study were confident in stating that they were aware of their personal culture, and there was some awareness on how this could translate into stereotypical and discriminatory behaviour.

[11] A term that describes attitudes, practices and policies within a system or organisation that causes harm to a cultural group.

Unconscious bias training was deemed to be useful to midwives in unpacking the issues around personal and professional biases. MW 3 expressed how she had benefited from unconscious bias training:

> *'It was just interesting going through it myself, if that makes sense, because I think a lot of times, we all kind of like… know about our bias, but we don't necessarily know who it impacts or how.*' (MW 3, qualified three years).

Midwives in both focus groups positively evaluated unconscious bias training, although their responses were limited in how they effectively applied this to their practice. The efficacy of unconscious bias training has been challenged in the literature (Dobbin & Kalev, 2018; Möller et al., 2024; Noon, 2018). It is argued that although training can reduce unconscious bias it is unlikely to eliminate it (Atewologun et al., 2018). It is suggested that individuals who are racist and are motivated to change, can be impacted by structural constraints that militate against pro diversity actions (Noon, 2018). However, Zhu (2023) defends the need for training, stating that individuals can gain insight into and reduce their unconscious bias and gain enhanced awareness of potential influences on their actions. Only a few studies on migrant African women indicated a specific need for unconscious bias training, although there were several recommendations for cultural competency or cross-cultural training, which may have included some elements of unconscious bias awareness (Degni et al., 2012; Higginbottom et al., 2019; Murray et al., 2010; Shorey et al., 2021; Tobin et al., 2014). This study shows that unconscious bias is a tool that can amend midwives' misconceptions, but there is an undertone of ambiguity of how this is concrete in its application to practice requiring further investigation.

Cultural frameworks of midwives are claimed to differ to that of the woman, so recognition of differences is important in care provision (Oscarsson & Stevenson-Agren, 2020). The narratives from the interviews with mothers showed that midwives did not directly discuss culture with them. Thereby, raising the question of how the process of cultural awareness was undertaken. This shows some ambiguity in midwives understanding of what cultural awareness entailed, as asking questions about a person's ethnic cultural background is a necessary component (Campinha-Bacote, 2002). The revelation of non-discussion of culture by midwives with the mothers in this study may have been due to discomfort in exploring this, or more likely unawareness. This study provides a different perspective to Moscrop et al's (2019) evidence on healthcare providers asking

patients about socioeconomic status, who found that there was fear of crossing professional boundaries or information obtained being inaccurate or unnecessary. Collecting information on sexual orientation and gender identity has also been met with difficulty by healthcare providers (Maragh-Bass et al., 2017). The fear of cultural racism which refers to institutional domination and racial ethnic superiority of one social group over another (Chua, 2017), is proposed as another factor that may have caused midwives' omissions in asking women about their culture. These omissions could also have been influenced by midwives not wishing to be seen as differentiating individuals and therefore, perpetuating classical or biological racism[12] (Rodat, 2017).

Communication as a precursor to cultural awareness is echoed in other studies (Tobin & Murphy-Lawless, 2014; Aquino et al., 2015). This study extends this theory that effective and relevant communication is vital for increased cultural awareness. Cultural unawareness suggests limitations in midwives' practice, caused by poor communication skills and access to cultural competency training (Drame et al., 2021). The scarcity of positive responses from mothers in the present study, regarding a targeted question about their culture indicates that this was not at the forefront of the midwives' minds during routine antenatal care provision. Demonstrating a lost opportunity for midwives to effectively engage with the process of cultural awareness by communicating with women and asking the necessary questions. Exploration of culture with migrant women is argued to be an important stance in antenatal care provision (Esegbona-Adeigbe, 2018; Lyons et al., 2008; Mohale et al., 2017). This study's findings demonstrated that the mothers did not have this experience, as reported by Toyin:

> *'I don't think we had anything that had to do with culture.'* (Toyin, first baby)

Mothers in the present study, reported that midwives asked them to state their country of birth, or the midwife was also Nigerian, which made them believe that a question about their culture was redundant. This view was in line with other studies, where midwives' awareness that the woman was from another country was obvious due to their known immigration status and physical appearance (Degni et al., 2014; Goberna Tricas et al., 2005; Tobin et al., 2014). However, how

[12] A belief that human species can be divided into biological distinct races, who share the same characteristics with no differences in between individuals

midwives used the woman's immigration status to ask about their culture is limited in the literature. In Degni et al's (2014) study, Somali women reported disengagement with healthcare professionals, with one mother stating, '*One can see that they are not interested, not caring about us like 'patients*.' Disengagement was not echoed in the present study; mothers provided their own reasons of why their culture was not discussed such as their country of origin being documented in their notes or stating it was obvious that they were from Nigeria. It was unclear in this study why midwives failed to directly discuss women's culture during the provision of antenatal care. Therefore, a gap in the evidence is identified, requiring further investigation.

In this study, the misconception of the 'strong Black woman' arose as a unique contribution to existing knowledge and how this impacted on pregnancy outcomes. Midwives articulated that this misconception impacted negatively on the provision of culturally competent care, particularly when assessing and planning care for women. The misconception of the 'strong Black woman' was stated to misconstrue midwives' perceptions of women's needs and led to assumptions about how their pregnancy should be managed. This misconception is already evident in the literature, with beliefs that Black women can tolerate physical and emotional pain due to their ethnicity (Graham & Clarke, 2021; Liao et al., 2020: Nelson et al., 2016; Thorpe et al., 2024). The 'strong Black woman,' has also been revealed in American studies, a legacy from the Transatlantic slave trade (Liao et al., 2020). The 'strong Black woman' was reported by mothers in a survey of Black mothers' maternity experiences in the UK, revealing poor quality care (Peter & Wheeler, 2022). Dike's (2019), study with midwives described how they viewed Nigerian women as being 'strong and amicable.' Echoes of the 'strong Black woman' were found in Birthrights' (2022) report 'Systemic Racism, Not broken bodies,' which illustrated the treatment of Black women, with individuals describing interactions that were dehumanising and demeaning. In this study the misconception of the 'strong Black woman' was stated to be deep rooted and common knowledge in Black communities and was revealed by the midwives in the focus group with only Black ethnicity.

Distinctly in this study the Black midwives stated that they pre warned Black women about their risk of having poorer outcomes and encouraged them to speak up if they had any concerns during pregnancy about their care. Midwives adopted this stance of preparing women to challenge any issues in their pregnancy care as they felt that maternity services were not able to effectively address these misconceptions that contributed to increased mortality for Black mothers. The Black midwives were passionate when they made these remarks, stating that the continued racial

disparities in pregnancy was ongoing. Therefore, strategies of arming women with additional information was seen by midwives as the most practical stance in the current climate of stretched maternity services. However, other approaches such as educating women on when to seek advice and help and reconfirming this at each antenatal appointment would have been appropriate. A robust review of any risks at every contact throughout pregnancy would have been a more feasible approach which was promoted in the Ockenden report as women's circumstances may change (Ockenden, 2022).

I reflected on the misconception of the 'strong Black woman' leading to midwives forewarning women about their risk of mortality. Pregnancy is an inherently worrying time for women; therefore, mothers being told by midwives that they were at increased risk of dying would have increased their anxiety. It is suggested that this ideology of Black women, can potentially be empowering but also marginalising (Carter & Rossi, 2021). Black women may take pride in being resilient and able to cope in times of stress, however this stance should not be expected by maternity care providers during pregnancy and childbirth. The misconception of the 'strong Black woman' is stated to lead to unrealistic expectations of self-care (Watson & Hunter, 2016). In this study, most Nigerian mothers had a positive demeanour and laughed through some of the difficulties they had faced during their pregnancy care. Issues ranged from not being heard and listened to, and for one mother it took a few appointments to have her concerns actioned by the midwife. Some mothers who had difficult encounters with midwives, shrugged off these experiences as part of the role of being a new migrant in the UK. Therefore, this acceptance by mothers may have been viewed by midwives as a coping mechanism.

It was noted that the misconception of the 'strong Black woman' was not reported in the focus group which had a mixture of White and Black midwives. This may have been a topic that was difficult for Black midwives to discuss in the presence of White midwives and may not have been the case if the focus group interviewer was White in either of the focus groups. This misconception may also not have arisen if the focus group consisted of only White midwives with a White interviewer. Other reasons why the mixed ethnicity focus group did not raise the issue of this misconception, such as unawareness or no experience of this issue or believing this was not the platform to discuss their experiences are possible.

Essences of the ‘strong Black woman’ was also expressed by the mothers in the present study. The words ‘because you are Black’ were stated to two women by their midwives, highlighting midwives’ awareness that being ‘Black’ was a potential for different experiences of antenatal care. This study adds to the knowledge, that staff misconceptions lead to limited involvement of women in their pregnancy care, disregarding their needs and preferences (De Freitas et al., 2020). The perpetuation of such misconceptions devalues women’s human rights to be treated as individuals and results in adverse pregnancy outcomes (Birthrights, 2022). New insights emerged in this study on how midwives used forewarnings to counteract the impact of the misconception of the ‘strong Black woman’ on Black women’s maternity experiences. Consequently, a significant contribution to the evidence is made that misconceptions of the ‘strong Black woman’ are present within contemporary maternity services.

6.4 Cultural skill

The findings from this study indicate that midwives recognise the value of cultural skill but are hindered by organisational factors. Cultural skill involves collecting relevant information and conducting culturally appropriate assessments of service users (Papadopoulos, 2006). Collection of individual’s beliefs and values and physical examinations to acquire knowledge about a person’s biological and psychological variations are essential elements of cultural skill (Campinha-Bacote, 2002). In Shorey et al’s (2021) qualitative meta synthesis on cultural competency of maternity health providers, no evidence was found related to cultural skill showing a gap in the evidence. The present study builds on the work of Shorey et al. (2021), as midwives stated that they frequently adopted the approach of asking questions and exploring with women their cultural needs. This information was used to develop a plan of antenatal care which was appropriate for the woman, as articulated by MW 3:

> *‘I usually like to lead the appointment with, do you have any questions for me or like, do you have anything that you want to talk about first?*’ (MW 3, qualified three years)

This study found that the execution of cultural skill was dependent on midwives’ experiences, and opportunities to engage with migrant women. The antenatal booking appointment was noted to be crucial by midwives for collecting the relevant information to plan the woman’s pregnancy journey. NICE (2021) recommends additional or longer appointments for women depending on their

medical, social, or emotional needs. Midwives demonstrating that they realised the value of asking appropriate questions to acquire vital information from women builds on my previous work (Esegbona-Adeigbe, 2018). Ongoing work conducted by the NHS Race and Health Observatory (NHS RHO), focuses on promoting effective and respectful communication with ethnic minority women as poor communication was a prevalent theme in causes of maternal mortality (NHS RHO, 2023). Exploration of women's needs is a crucial element of cultural skill, hence communication in a culturally sensitive manner is argued to be necessary (Esegbona-Adeigbe, 2022; Schouten et al., 2020; Zegers & Auron, 2022). Midwives' narratives were in line with this theory as they recognised the importance of allowing women to 'open up,' thereby extracting detailed information during antenatal appointments. Midwives indicated that effective communication was necessary when planning care for women from different cultures as the absence of this impacted on planning appropriate care. The open and sensitive communication tactics highlighted in both focus groups adds to other views that this was necessary for optimal and culturally appropriate care (Brooks et al., 2019; Crawford et al., 2017). The focus group that consisted of only Black midwives revealed a motivation to ensure that Black women were able to communicate their pregnancy wishes. Midwives described a process of assessing, retrieving, assimilating, and gathering information, and attention to cultural preferences were at the forefront of these assessments. This study supplements reflections from the 'Systemic racism, not broken bodies' report from one midwife (Birthrights, 2022)

> *'It means listening to people in our care. Respecting their choices as theirs to make. Always giving evidence instead of just assuming Western ideas are the best and other choices are inferior.'* (p 25)

The present study demonstrated that midwives regarded listening as a valuable skill which showed the woman that her wishes and desires were being heard, adding to the work of McKenna et al. (2020). Midwives provided reasons why listening was an essential component of antenatal care provision, as stated by MW 6:

> *'…You know, no one can be expected to be completely aware of anyone, you know… of everyone's full catalogue of possibilities. But... It is about listening.'* (MW 6, qualified two years)

Midwives did not discuss other non-verbal communication skills in their interactions with women, contrary to the utilisation of nonverbal communication such as facial expression, silence and touch which are stated to be just as effective as listening (Kacperck, 1997; McKenna et al., 2020). Understanding cultural norms surrounding eye contact, tone of voice can prevent miscommunication which contributes to poor health outcomes (Kwame & Petrucka, 2021). Complementing Kwame and Petrucka's (2021) findings, this study found that midwives conducted women centred communication during their antenatal care and were responsive to their health concerns and beliefs. However, there was limited discussion on any non-verbal strategies that could supplement communication which requires further investigation.

Building a rapport with women was strongly advocated by midwives in the present study, as a requisite of culturally competent care. This was not directly alluded to in other studies. Mistrust within Black communities was stated by one focus group as one reason women did not want to engage with antenatal care. This mistrust of healthcare services is reported widely in the literature compounded by racism and discrimination (Cénat et al., 2023; Devonport et al., 2023; Newman, 2022). Midwives in this study mitigated mistrust by showing women that they were interested in their views, adding to the evidence, that building trust is recognised as being vital for cross cultural communication (Breakwell, 2020; Kwame & Petrucka, 2021). Midwives' mitigating mistrust in women was contrary to reports of dismissive and indifferent behaviour from health care professionals which led to migrant Black women not having their preferences incorporated into their care, as described by one participant in Azugbene et al.'s (2023) study:

> *'…Excuse me,'' I want to talk to them. And it's like a doctor and nurse together. They came to see me, and they just looked at me like this. Nobody touched me, nobody asked me any questions. They just turned around and they're talking together. And I said, ''Excuse me, excuse me.'' Nobody wants to hear me. They hear what I'm saying, but they don't want to talk to me…' (p 609)*

The midwives in the present study showed their understanding of the pertinent issues surrounding mistrust and the impact on effective communication. Midwives understood how discrimination could worsen mistrust and lead to women's loss of confidence in maternity services. This study demonstrates that knowledge of mistrust in Black communities motivates midwives to build a rapport with women and make them understand that they are equal partners in their care.

Language barriers were the most common communication issue discussed by midwives in this study. Language difficulties were reported to have a negative impact on all aspects of delivering culturally competent care as found in other studies (Bulman & McCourt, 2002, Hill et al., 2012; Kwame & Petrucka, 2021; Murray et al., 2010). UK National maternity care guidance recommends the use of professional interpreters when communicating with pregnant women who have a language barrier (Knight et al., 2023; NICE, 2021). In line with other studies, midwives admitted challenges in communicating with migrant women if there was no access to appropriate interpreters. Inadequate use of interpreters was not an intended action by midwives but an unavoidable obstacle to undertaking culturally appropriate assessments. Issues ranging from women's request for a female interpreter and unavailability of appropriate translation services were discussed in both focus groups. Midwives explained that diversity of languages meant that often an interpreter that spoke the woman's dialect was unavailable or interpretations services were limited. These are common obstacles in maternity services due to the increased diversity of languages in the UK childbearing population (Chitongo et al., 2022; MacLellan et al., 2024). Furthermore, fear of breach of confidentiality and poor translation of medical terminology also impacts on migrant individual's experiences of interpretation services (Cull et al., 2022; Patel et al., 2021).

Interpretation impediments is a recurrent theme in many studies with migrant women (Bulman & McCourt, 2002; Fair et al., 2020; Higginbottom et al., 2019; Konje & Konje, 2021). A sense of fear and isolation were increased by language barriers in Bulman and McCourt's (2002) study with Somali women in the UK. Issues of confidentiality being breached if the woman and the interpreter came from the same small community were discussed by Higginbottom et al. (2019). Concern that privacy may be breached potentially leads to lack of engagement and further distancing from perinatal services. Language difficulties even with appropriate language support has been underestimated by healthcare professionals resulting in fragmented and inappropriate care (Murray et al., 2010). The present study extends the knowledge that midwives frequently have to overcome barriers when using interpretation services, but they are aware of the skills required to communicate with women effectively and acquire necessary information.

Women who speak English as a second language still experience language barriers as shown in this study. This led to fragmented care and increased anxiety for mothers, particularly if they had a medical condition. This led to mothers either not being able to follow health advice or seeking

information from other sources, such as family or friends or in some cases, healthcare professionals in Nigeria. All the mothers in this study spoke English, but participants reported communications errors such as not understanding medical terminology and dietary and lifestyle advice. These reports supplement the evidence from other studies that even with proficiency in English, communication issues can still occur (Konje & Konje, 2021), highlighting the need for culturally competent communication (Oscarsson & Stevenson- Agren, 2020). It is noted that the midwives in this study did not articulate any concerns around communicating with English speaking migrant women, despite mothers' views. The present study builds on the available evidence that language barriers exist for English speaking migrant women, particularly if the medical terminology used is complex as demonstrated from the mothers' narratives.

Midwives' cultural skill was noted in this study with positive and negative experiences reported by mothers. Most mothers in this study valued this and discussed that midwives were open and accommodating and they felt they were able to ask and answer questions. However, some mothers reported issues with time allocated for their antenatal appointments and a midwife stating '*OK we are done,'* for one participant removed any desire to discuss any concerns. These findings demonstrate the importance of utilising adequate time and sensitivity in cross cultural communication which is required for facilitating an open approach and listening. Perceptions that midwives did not have time conveys to migrant women that there is lack of support (Murray et al., 2010). Lack of time has also been perceived in the busyness of healthcare providers resulting in women feeling misunderstood and that their customs and values restricted their ability to acquire information from women and therefore, they economised their questioning during antenatal care provision.

Mothers in the present study were asked to discuss their relationship with midwives and positive experiences were divulged, as stated by Abi:

> *'Because I am so used to her and… you know she started with me, and we are doing the following up without…without distraction …she already knows everything about me in every of my appointments, I just fall in love with her that's its.'* (Abi, third baby)

This positive interaction support findings from Fair et al 's (2020), systematic review, where migrant women reported compassionate and empathetic care from healthcare professionals, although one

could not determine if this included midwives. The present study extends the knowledge that midwives creating time, listening to mothers, and making them feel that their options mattered are crucial components of culturally appropriate assessments.

It is shown in this study that midwives were inadequate in certain aspects of their assessments of migrant women. Several mothers had booked after 20 weeks of pregnancy which should have acted as a signal to midwives to assess why they had attended late for antenatal care. However, most mothers stated that they did not have any discussion on why they had booked late. This is pertinent as there was a conflict with the NICE recommendations, that women should book for pregnancy by ten weeks gestation (NICE, 2021). The importance of early booking for pregnancy has also been recommended by maternal mortality reports, as good antenatal surveillance reduces a woman's risk of maternal death and morbidity (Knight et al., 2021, 2022, 2023). Significantly, midwives' omissions indicated that they did not connect any importance to the mother booking late for pregnancy. Mothers provided several reasons why they booked late for pregnancy, with issues ranging from not knowing how the referral system worked, protracted referral pathways and unavailability of appointments. These findings build on the available knowledge on barriers to migrant Black African women accessing maternity services. In addition, practical implications are highlighted in this study that midwives absolve importance to the issue of migrant women booking late for pregnancy.

6.5 Cultural knowledge

Migrant women may have left behind a culture in which they were understood, impacting on their pregnancy preferences in a new country (Carolan & Cassar, 2010). Hence, this study highlights the potential for this cultural void to lead to poor pregnancy experiences. This study shows that migrant mothers are not asked about their migration experience by midwives and mothers did not offer this information voluntarily. A desire to not be seen as a migrant woman was a theme throughout the stories told by mothers, they did not want to be treated differently to other pregnant women. This view was consistent with migrant African women's views in a study conducted by Degni et al. (2014) in Finland, with one mother explaining the following:

> '*I am a Somali, I speak Finnish but when I go to the hospital, I leave my Somali cultural way of thinking and religious beliefs at home and behave like (a) Finn in the hospital.'* (34 years) (p 12)

In the present study, some mothers attempted to integrate into the dominant UK culture, which supports the theory from Sam and Berry (2010), where an individual has a desire to maintain their own culture and willingness to participate in the new culture. Negotiating two cultures is evident in the literature for migrant women (Bassel & Khan, 2021; Pangas et al., 2019). Mothers in this study alluded to being stressed when trying to adapt to the UK culture. It was clear from mothers' stories that they had resilience and strength which aided them during their migration journey, attributes reported in an integrative review of African women's migration experiences (Babatunde-Sowole et al., 2016). However, acculturative stress[13] has been experienced by migrant women which impact on their emotional and mental well-being (Greenwood et al., 2014; James et al., 2022). Only a few mothers in this study were asked about their migration journey by midwives, which would have provided a platform to share any issues related to living in a new culture. The mothers in this study were all economic migrants[14], which has been linked to less acculturative stress than women who are forced to leave their countries (Choy et al., 2021; Sam & Berry, 2010). However, mothers did reveal that they experienced stress as a migrant. The vulnerability of mothers regarding trying to navigate their lives between two cultures are exposed in this study. These vulnerabilities such as isolation and changes in personal identity due to migrant status are in accordance with Azugbene et al's (2023) findings, in their study of migrant Black African women in the USA, who were subjected to forced migration and subsequent settlement. The issues created by forced migration were similar to migrant Black mothers in this study who had migrated voluntarily. Pressures caused by migration were also reported by Strauss et al. (2009) and Balaam et al. (2023), taking precedence over women's pregnancy needs. This study provides further evidence on the importance of midwives having some insight into women's migration experience and the implications for midwifery clinical practice.

---

[13] Acculturative stress – Stressors associated with being a migrant and going through the acculturation process

[14] Economic migrants – A person who leaves their country for economic reasons to seek material improvement in their livelihood.

The current study found that mothers did not wish to expose their cultural practices to outsiders for fear that it would be seen as unlawful. Thus, highlighting uncertainty experienced by migrant women of what were accepted cultural practices when living in a dominant culture. Mothers reported that concealing their pregnancy was a cultural norm due to fear of causing harm or inviting bad luck. This was mainly in the context of not discussing pregnancy outside of close family and friends. However, there were some references that a pregnancy may not even be revealed even to healthcare professionals. These results fit with the theory that concealing a pregnancy is a widespread practice in many African countries due to fear of harm to the baby from evil spirits or ill wishes from outsiders (Parrish et al., 2023). Mothers alluded to Illicit cultural practices being conducted in the UK, which was in line with other studies which found that ingestion of calabash chalk (a poisonous substance taken by African women to curb morning sickness) were continued in the diaspora (Madziva & Chinouya, 2020). This cultural norm instigated Public Health England to issue a press statement to general practitioners to dissuade women from this practice (Public Health England, 2013; Madziva & Chinouya, 2020). Mothers reported that a focused discussion with the midwife on certain practices may have alleviated their concerns and provided reassurances. Whilst previous research has focused on midwives forewarning women on unsafe cultural practices in pregnancy this study builds on the existing evidence showing that cultural knowledge is required to have a shared discussion of such practices. Significantly, no other studies revealed this aspect of concealing cultural practices, providing a new perspective of migrant Black African mothers.

This study indicates that some discussion with mothers about their cultural preferences would have been useful, in relation to rituals surrounding the placenta and diet. One mother in this study, Ola, discussed the importance of performing a placental ritual after the birth of her baby and mourned the loss of this opportunity. I remembered her disappointment and how she shrugged off the experience, and I felt the resignation that she displayed during the interview. In many Indigenous societies, pregnancy and birth are not just biological events but are socially and culturally constructed (Ohaja & Anyim, 2021). Therefore, rituals surrounding pregnancy are continued in the UK, depending on acculturation, value of motherhood, social support and religion and spirituality (Dike, 2013; Esegbona-Adeigbe, 2011; Ngongalah et al., 2023). African cultural rituals around pregnancy continue in the diaspora due to the belief that the baby is protected is evident in the literature (Dike, 2013; Esegbona-Adeigbe, 2022). One mother wished she had been provided with culturally specific dietary advice to manage her gestational diabetes and consequently struggled with following the dietary recommendations from her midwife. The consideration of cultural

practices of women during antenatal care provision can lead to high quality, culturally sensitive care (Esegbona- Adeigbe, 2018; Sarantaki et al., 2020). Cultural insight was recommended by Sarantaki et al. (2020), as an important aspect when providing antenatal advice to migrant Black African women. This study further heightens the importance of the midwife providing culturally specific advice.

Mothers' narratives demonstrated that they prioritise their religion over their culture and sought solace from their faith when making any decisions about their pregnancy. This revelation builds on Hill et al's (2012), study with Somali women, who referenced religion as being more important than their culture. The mothers' faith was evident in this study as they described how challenges or difficulties during their pregnancy were managed by leaving it up to God, rather than trusting in technology and medical advice. This study also builds on the findings from migrant women in Hill et al's (2012) study who were fearful of relying on technology during their pregnancy and did not wish to have any interventions, preferring to allow events to take their natural cause. Fear of medical and obstetric interventions has been found in other studies with migrant African women (Azugbene et al., 2023; Goberna Tricas et al., 2005; Sarantaki et al., 2020; Wojnar, 2015). In the present study, Ife, revealed that having a vaginal birth was a cultural expectation for a mother to be seen as a real woman:

> *'And back home nobody* (wants) *to hear about operation … If you want to go for childbirth in Nigeria you don't want to hear that you will be going through operation.'* (Ife, third baby)

Negative experiences associated with childbirth is reported to lead to distress and psychological trauma (Thomson & Downe, 2016), and it is suggested that if cultural expectations are not met this could result in similar consequences. Women in the present study used a combination of culture and religion to sanction their decisions around pregnancy and childbirth. Therefore, a clearer understanding of the role religion plays in supporting women during pregnancy and childbirth is highlighted in this study. Furthermore, this study strengthens the importance of midwives facilitating the type of birth that adheres to a woman's cultural expectation.

The data indicates that mothers appreciated contact with midwives in the UK, despite differences in expectations, organisation of antenatal care provision was positively evaluated. Access to health

advice and medication was different in Nigeria compared to the UK. Mothers reported that they could walk into healthcare facilities in Nigeria and see a doctor, and consultations and most medications could be received from pharmacists. Several mothers reported barriers to accessing antenatal care which had a subsequent impact on their antenatal experiences. This was due to different referral pathways in the UK compared to Nigeria. In line with previous theories, lack of knowledge of how the UK health service operates can be a barrier to new migrants engaging with care (Ahmadinia et al., 2022; Isaacs et al., 2022). Other studies have shown that in some cultures, pregnancy is seen as a normal state, therefore detailed antenatal surveillance is deemed unnecessary by women (Azugbene et al., 2023; Carolan & Cassar, 2010; Konje & Konje, 2021). These views were not replicated in this study, with mothers discussing their knowledge and experiences of pregnancy, particularly around care being delivered by doctors in their country as opposed to midwives in the UK. However, mothers reported the lack of continuity of carer in the UK which was routinely offered in Nigeria and long waiting times which made it difficult to discuss anything let alone their cultural preferences with midwives. This is consistent with views of Somali women in Strauss et al's (2009) study and Dike's (2019) study with Nigerian women in the UK, where it was reported that in their own country, they would see one person during their maternity care. In a scoping review on the implementation of models of continuity of care, except for New Zealand, no country provided continuity of carer at a national level (Bradford et al., 2022). Demonstrating that migrant women may not be offered continuity of carer routinely in the UK. The Royal College of Midwives (RCM), state that quality of care is improved by providing individualised and responsive care to women (Cbe, 2017). It is unquestionable that some mothers in the present study had poor experiences of antenatal care impacted by lack of individualised care. This is in line with Downe et al's (2018) study who found that maternity care that meets women's sociocultural values and expectations can lead to a positive birth experience. The impact of lack of continuity of carer on the mother's ability to share cultural knowledge due to unfamiliarity with the midwife adds to the body of evidence regarding care provision for migrant women.

This study shows that some mothers viewed midwives' lack of cultural knowledge as unimportant during their antenatal care. However, it was noted that mothers who were pregnant for the first time, had a different view and felt they would have benefited from the midwife having knowledge of some African cultural practices. Mothers stated that this would have facilitated sharing of information or at least created an opportunity to discuss their culture. It was reported that midwives did not demonstrate cultural knowledge particularly around diet and postnatal practices. Similar dissatisfaction in their care was reported by Somali mothers in Strauss et al's (2009) study, who

complained about midwives' knowledge deficits in FGM, resulting in mismanagement of care causing physical and mental distress for mothers. Women have experienced poor pregnancy care due to healthcare providers' lack of knowledge of cultural practices (Higginbottom et al., 2019). Increasing education for healthcare professionals on culture was advocated by women and men in Wojnar's (2015) study. One mother in the current study did not fault midwives' lack of cultural knowledge, explaining that due to the diverse communities in the UK, it would be difficult to acquire adequate cultural knowledge. In contrast, another mother who was a healthcare professional, verbalised that midwives have a responsibility to learn about different cultures if they are working with a diverse community, in keeping with views of other migrant African women (Fair et al., 2020; Konje & Konje, 2021; Wojnar, 2015). This study confirms that cultural knowledge plays a significant role in facilitating women's cultural preferences, providing a clearer understanding of migrant women's expectations of the midwife's role.

The analysis found evidence that mothers' views on midwives' level of cultural knowledge was linked to educational status and previous experiences of childbirth. Perceptions of cultural needs and desire has been found to be influenced by women's health literacy (Mohale et al., 2017; Ward et al., 2019). Women's educational status and previous experiences have been found to benefit their interactions with midwives (Oscarsson & Stevenson-Agren, 2020; Shorey et al., 2021). It is suggested that there are cultural influences on health literacy, affecting how individuals respond to health recommendations, health interventions and treatment adherence (Levin-Zamir et al., 2017; Shaw et al., 2009). Indicating that migrant women's adherence to midwifery advice depends on any conflicts with any cultural norms, despite understanding any risks to their health. Most of the mothers in this study were educated to university level (n=14) and they did not report issues with adhering to advice given by midwives or any conflicts with their cultural beliefs. Health illiteracy is stated to be linked more strongly to ill health, than lower educational status or ethnicity (NHS England, 2024). This study contributes to the evidence that the higher educational status of mothers was beneficial in their acceptance of medical advice that conflicted with their cultural practices.

Professionals' deficiency in knowledge about migrant women's culture can lead to a lack of cultural sensitivity (Degni et al., 2014; Drake et al., 2022; Konje & Konje, 2021). The acquisition of cultural knowledge was reported as being important by midwives in this study, needed to facilitate the ability to adapt care for migrant women if this was within their remit or ability. Adapting care was

not evident in other studies, where in contrast migrant women were expected to adjust to healthcare services (Lyons et al. 2008; Tobin & Murphy-Lawless, 2014). An assimilationist approach was adopted by midwives in Ireland, as additional demands on the existing health care system was unwelcomed (Lyons et al. 2008). Tobin and Murphy-Lawless (2014), found that midwives expected migrant women to adjust to medicalised maternity services regardless of their cultural preferences. It has been recognised that migrant women have complex socioeconomic needs which impact on their pregnancy, which midwives struggle to accommodate in routine antenatal care (Aquino et al., 2015; Fair et al., 2020; Puthussery, 2016). However, in the present study, midwives empowered women and managed their expectations to facilitate their engagement with antenatal care. This builds on Mohale et al's (2017) study who advocated the empowerment of migrant Black African women, stating that this positively influenced their ability to engage in pregnancy care. Empowerment has been linked to an ability for women to make choices, whilst disempowerment has been linked to poor communication (Mohale et al., 2017). Limited cultural knowledge impedes the task of empowering migrant women, as understanding of women's priorities is required to assist their choices. Furthermore, healthcare professionals' lack of cultural knowledge is deemed to be an impediment to quality antenatal care as cultural beliefs shape how women respond to healthcare advice (Wojnar, 2015). Emphasis on acquiring cultural knowledge has been suggested to lead to stereotyping, stigmatising and 'othering' of individuals (Lekas et al., 2020; Young & Guo, 2020). The current study supports the view that possessing cultural knowledge e.g. norms and customs, is useful for cultural awareness and culturally appropriate communication (Esegbona-Adeigbe, 2011; Shepherd et al., 2019).

This study asserts that midwives had some cultural knowledge, but they recognised that it was impossible to be knowledgeable about all cultures. This was in line with other views, that such knowledge is difficult to achieve when caring for very diverse populations and that there are limits to attaining knowledge of all cultures (MacKenzie & Hatala, 2019). Midwives' recognition of their deficits in cultural knowledge has been reported in other studies (Goberna Tricas et al., 2005; Lyons et al., 2008; Murray et al., 2010). Midwives reported contact with a variety of Black African women and therefore, learnt or became aware of cultural practices due to these interactions. Building a picture of women's cultural needs were reported as requiring effort and time, which midwives were willing to accommodate. In contrast, Balaam et al. (2013) addressed the lack of connection between health care providers and migrant pregnant women, resulting in an inability to meet their needs. Difficulty in making emotional connections with women were also described by Tobin and Murphy-Lawless (2014), demonstrating clear differences to the reports provided by

midwives in this study. Goberna Tricas et al's (2005) view was that knowledge of diversity and respectful dialogues between people from different cultures are of special importance in contemporary midwifery practice which is supported by this study. Gaps in midwives' cultural knowledge is stated to decrease their ability to provide appropriate care (Lyons et al., 2008). Significantly, no narratives from the focus groups suggested that lack of cultural knowledge was a barrier to providing quality antenatal care. This was a positive finding as conflict between health care professionals and migrant Black African women in relation to traditional customs impact negatively on maternity care experiences (Fair et al., 2020). The present study confirms that the sharing of cultural knowledge can be improved when maternity care is responsive to mother's needs.

This study shows that midwives understood it was a cultural norm for migrant women to include family members in decisions made about their pregnancy. This builds on Shorey et al's (2021) findings, where maternity care providers respected and embraced family involvement when making decisions about women's care. It was stated by midwives in this study, that some family members acted as gatekeepers, preventing migrant women from accessing care or taking choice away from them. Hence, midwives attempted to function as advocates as well as mediators between women and their family members. In other studies, men have stated that they wanted unconditional respect for their culture and have deep rooted beliefs about their pregnancy care (Wojnar, 2015). Therefore, the consideration of migrant men's cultural views is important when providing pregnancy care to migrant women, which was not revealed in the present study. Mothers did not refer to their partner's cultural views during the interviews. Most of the mothers were married (n=13) and only a few mentioned their partners, regarding seeking their advice and support when making decisions about their pregnancy care. This study provides further insights into family members and men's role in women's decision-making during pregnancy.

Cultural safety is stated to be more relevant to healthcare provision than cultural knowledge (Curtis et al., 2019; Wilson et al., 2022). Protecting the cultural identity of the woman is a crucial factor in cultural safety, but transferring this to clinical practice is challenging for midwives (Capper et al., 2023). Midwives did not verbalise any understanding of cultural safety in the current study. However, feeling safe was an aspect discussed by some mothers which they stated was more important than midwives' cultural knowledge. In contrast, other mothers reported that midwives having some cultural knowledge would have made them feel safe to discuss their preferences.

Therefore, this study provides two perspectives on the benefits of midwives' cultural knowledge to mothers. The notion of acquiring cultural knowledge has been suggested to lead to stereotyping, stigmatising, and 'othering' of individuals (Lekas et al., 2020; Young & Guo, 2020). Furthermore, as cultural awareness and cultural skill are required to explore cultural norms with mothers, it is evident that cultural safety cannot be achieved without the use of these constructs. The importance of feeling safe was not explicitly found in other studies with migrant women, however the essence of cultural safety, such as protecting the woman's cultural identity was alluded to in many studies (Mohale et al., 2017; Murray et al., 2010; Sarantaki et al., 2020; Wojnar, 2015). This study demonstrated that elements of cultural competency are necessary to facilitate cultural safety.

6.6 Cultural encounters

Cultural encounters with migrant women are essential in acquiring cultural knowledge and to enhance cultural awareness and sensitivity (Campinha- Bacote, 2002; Esegbona-Adeigbe, 2011). In this study, midwives acknowledged that caring for mothers from different cultural backgrounds contributed to their cultural knowledge. Barriers to these cultural encounters were communication issues which has been confirmed in several studies with healthcare professionals (Aquino et al., 2015; Bulman & McCourt, 2002; Degni et al., 2012; Goberna Tricas et al., 2005; Oscarsson & Stevenson-Agren, 2020; Tobin & Murphy- Lawless, 2014). Midwives contact with migrant women was a daily experience, this may not have been a similar experience for midwives who worked in more rural areas due to less diverse populations. Midwives valued the impact of cultural encounters to their knowledge, which was in line with Goberna Tricas et al's (2005) research, where limited contact with migrant African women resulted in midwives requesting training on their cultural practices. Additionally, frequent contact with Somali women in health clinics and in their homes was observed by midwives as an opportunity to understand their culture (Degni et al., 2012).

Other studies have observed that the lack of experience in meeting Black African women could create equivocal emotions in midwives (Oscarsson & Stevenson-Agren, 2020; Tobin & Lawless-Murphy, 2014). This study adds another layer of knowledge, as midwives demonstrated a greater understanding of women's experiences due to cultural encounters, resulting in closer relationships and the use of tactics to collaborate with women. Oscarsson and Stevenson-Agren (2020), discussed the importance of these relationships, where midwives developed increased understanding of migrant women's situation. It was suggested that following women through

several pregnancies led to midwives being viewed as family members (Oscarsson & Steven-Agren, 2020). The findings from both focus groups revealed that continuity of care was beneficial in maintaining contact with migrant women, thus enhancing the quality of midwives' cultural encounters. This builds on the evidence from Downe et al's (2019) qualitative evidence synthesis on provision and uptake of antenatal care, who found that continuity of care allowed staff to take time to provide relevant and supportive care that was culturally sensitive. One midwife in the current study who specifically case-loaded migrant women, found that the frequent contact assisted with communication and engagement during provision of antenatal care. This compared to other studies, where the quality of encounters with Black African women was impacted by the quality of communication (Bulman & McCourt, 2002; Harrison et al., 2019).

This study uniquely found that cultural encounters assist midwives to see the broader impact of society on women's cultural behaviour. Midwives used these encounters to reframe their beliefs about women's cultural preferences. These findings aligns with Campinha-Bacote's (2011) theory, that continuous encounters with women from culturally diverse backgrounds is required to validate, refine or adapt existing beliefs about a cultural group. Ting-Tomey (1999) argued that effective cultural encounters prevent the risk of stereotyping. This is contrary to midwives in this study who did not explicitly link the benefits of cultural encounters with the ability to reduce stereotyping of women. This may have been due to limited scope in the focus groups to explore this fully. Furthermore, midwives did not discuss acculturation and if they understood the impact of this on migrant women's cultural requirements. Hence, this study's findings contrasted with other views that extended contact with migrant women deepens midwives understanding of acculturation and how these impacts on migrant women's expectations (Oscarsson & Stevenson-Agren, 2020). The results from this study contribute insights into the value of cultural encounters in the development of cultural awareness, cultural skill, cultural knowledge, and cultural desire.

The evidence cast a new light on the existing organisational constraints of high workload and shortages of staff (Brader, 2024), creating barriers to positive encounters between midwives and migrant women. Although, it could be argued that this could be the case for all women. Midwives realised their increased responsibilities and accountability when caring for migrant women either due to language barriers or socioeconomic issues. It was clear that these obligations left midwives frustrated and resigned as they could not accommodate all migrant women's needs. This study brings further richness to Tobin and Murphy- Lawless' (2014), research which found that frequent

encounters with asylum seeking women led to midwives feeling powerless due to being exposed to traumatic stories of their experiences in leaving their homeland. Implicating that cultural encounters were not always viewed by midwives as an opportunity to improve care but as an additional agenda of issues that they had to support women with. Cultural encounters have been viewed negatively by midwives leading to recommendations of enhanced support for practitioners (Tobin & Murphy- Lawless, 2014). This study highlights the potential of cultural encounters as a useful component to enhance midwifery practice, however the infrastructure of the NHS does not appear to support these interactions.

Mothers explained that receiving care from a midwife who had experience of caring for other Black African women was useful in some respects. Furthermore, this study revealed that midwives who shared the same culture as the mother appeared to lessen the need for cultural encounters. This finding ties in well with other studies suggesting that ethnically diverse healthcare staff are needed to provide culturally competent maternity services (Shorey et al., 2021). One mother described her experience with a midwife, in relation to dietary advice when she was told to eat unfamiliar foods stating, '*I had never heard of broccoli.'* This led to some anxiety for this mother as she was unable to follow the dietary recommendations to manage her gestational diabetes. Uncertainty may be experienced by migrant women who struggle to find recommended food sources due to being given culturally inappropriate advice by midwives. This UK perspective builds on de Diego-Cordero et al's (2021) systematic review based on studies mainly from Asian and African countries, which found that migration and acculturation influences migrant pregnant women's eating habits leading to poor nutritional input due to an inability to source a recommended diet. There also are food taboos and restrictions which a midwife may be unaware of, which conflicts with dietary advice. Other mothers in the present study reported that they were offered dietary advice that they could follow as the midwife shared the same ethnicity. This study validates other studies with migrant populations which advised that dietary advice should be relevant to the individual's culture to avoid cultural conflicts (Chowdhury et al., 2023; de Diego-Cordero et al., 2021). This study confirms the importance of midwives providing culturally relevant healthcare advice.

A key finding that emerged in this study was mothers indicating that although they spoke English there were still issues in understanding the essence of what was being said by the midwife. One mother explicitly described how she became frustrated by the midwife not speaking *'normal*

English.' However, during a consultation with an obstetrician who was from the same culture, although English was spoken, this mother stated she understood clearly because: '*he spoke her English*.' Other mothers declared that they knew the midwives had experience of caring for other African women by the way they conveyed health information. Showing that culturally sensitive communication with English speaking migrant women deepens with cultural encounters or if the healthcare provider has a shared culture with the service user. Midwives' advice was misunderstood by migrant women in this study due to use of unfamiliar words and terms. These results support other views that culturally appropriate communication can be improved by cultural encounters, as there are nuances and particularities of speech and body language influenced by culture which is learnt by exposure (Esegbona-Adeigbe, 2022). Effective cross-cultural communication for migrant women who speak English as a second language requires specific skills, including explaining and avoiding medical jargon, checking understanding, paraphrasing, and repeating the woman's word to encourage elaboration of any concerns (Allen et al., 2023; Paternotte et al., 2015). The mothers in this study experienced language barriers due to miscommunication, building on Degni et al's (2014), theory that migrant women require open communication and clearer explanation of complex information. The value of cultural encounters mitigates communication issues as midwives in this study verbalised how they developed skills in conveying information to women in a culturally acceptable way. This study supports the theory that educated individuals have been found to have issues with understanding medical terms and common medical phrases causing confusion (Allen et al., 2023; Gotlieb et al., 2022; Hause et al. 2022). In line with Ting-Toomey (1999) and Draper et al., (2023) this study contends that effective cultural encounters contribute to mindful cultural communications and prevents inadequate assessments of women's understanding. A clearer understanding that proficient in English does not mean proficient in assimilating complex medical terms or health advice is provided in this study.

The analysis confirmed that non-English speaking women and inadequate interpretation services contributed to major communication barriers in maternity units. Midwives showed that effective encounters with non-English speaking migrant women were hindered by being unable to meet women's request for female interpreters or provide interpreters that spoke women's dialect. This was the case for face-to-face interpretation and telephone or online services. Furthermore, it was revealed that women feared using an interpreter due to concerns about privacy and confidentiality. This builds on MBRRACE's report which highlighted the inadequacy of interpretation services, with inconsistent provision and inappropriate use of family and healthcare professionals contributing to

adverse pregnancy outcomes (Draper et al., 2023). Midwives reported that using an interpreter raised concerns as they were unsure of the quality of interpretation and whether women were receiving the relevant information. Development of culturally trained professional interpreters are deemed to be the answer to language difficulties and cultural differences (Konje & Konje, 2021), but this does not address the unavailability of female interpreters and required dialects. Midwives in this study showed empathy for women who were reliant on the NHS to provide language support which was inadequate and tried to negotiate services for women by rescheduling appointments. This adds to the findings from Tobin et al. (2014), who stated that healthcare providers' cultural understanding facilitates culturally competent communication in the face of language barriers. This study uniquely provides another facet on how cultural encounters impact on midwives' cultural understanding and how they facilitate women's needs in the face of reduced resources.

A core finding in this study was that mothers sought further information between consultations with the midwives. Sources used by mothers in their information seeking were Google, family and friends and doctors, some of whom were in Nigeria and their current GP or health visitor. This utilisation of information resources outside of routine antenatal care provision by migrant women suggests the deficiencies in advice provided. Midwives in the present study articulated that they signposted women to appropriate resources, in line with findings from other studies (Higginbottom et al., 2019; Ngongalah, et al., 2023). However, it is argued that migrant women who access the internet, still need to understand the relevance and safety of any information retrieved. Furthermore, if mothers sought advice from family, friends or health care professionals not residing in the UK, as was the case in this study, there is a possibility that information retrieved is not recommended UK practice. Midwives' encounters with migrant women appeared to not consider these eventualities. Building on the work of Azugbene (2023); Sarantaki et al. (2020); Tobin et al. (2014) and Wojnar (2015), who recommended culturally sensitive information, this study supports the need for midwives to ensure that women are provided with culturally sensitive safe netting guidance when seeking health advice.

The evidence shows that migrant mothers are not offered antenatal classes by midwives resulting in a lost opportunity to engage with other pregnant women. It is apparent that mothers in this study were unable to explore medical concepts that were confusing or difficult to understand or share experiences with other women, which is a key benefit of antenatal classes (NICE, 2021). Antenatal

education would have been useful to verify any cultural queries mothers may have had, Temi particularly felt disadvantaged by not being offered antenatal classes:

> *'… I don't even have any opportunity to speak to any women that would have been pregnant at the same time that I was, I didn't really have a community life with colleagues… for pregnancy*.' (Temi, first baby)

Temi stated that her pregnancy was a lonely journey, particularly with limited friends and family living in the UK, demonstrating another insight into being a migrant pregnant woman. It is unclear whether midwives from previous encounters with other Black African women may have felt that antenatal classes were not desired. Therefore, cultural encounters may have some negative aspects in creating stereotypical behaviour around women's educational needs. Carolan and Cassar (2010) and Tobin and Murphy- Lawless (2014) recommended further research to identify the information needs of migrant Black African women. The present study shows that midwives did not use encounters with women to assess their need for antenatal education and did not recognise the value of these interactions to seek clarification of their educational needs. This has implications for midwifery clinical practice to consider the culturally specific educational needs of migrant women.

6.7 Cultural desire

Midwives had a desire to learn about different cultures and showed that they sought contact with migrant women. Cultural desire is argued to underpin the process of cultural competency, where individuals are motivated to provide culturally competent care (Isaacs et al., 2016). It is recognised that cultural encounters do not spontaneously translate into cultural desire, and it is argued that cultural desire cannot be taught and that this is an inherent action (Campinha-Bacote, 2008). The benefits of cultural desire was not overtly verbalised by midwives in this study but was alluded to in their discussions on the importance of listening and sharing information and being open to learn about women's culture. This aligned with other studies by Goberna Tricas et al. (2005), Lyons et al. (2008) and Wojnar (2015), who acknowledged that healthcare providers showed an interest in learning about cultural differences. The majority of midwives in the present study came from non-White backgrounds which supports recommendations that a culturally diverse workforce may boost cultural desire (Shorey et al., 2021). Cultural desire results in healthcare professionals acquiring considerable knowledge about migrant women's culture and customs (Wojnar, 2015). The building

blocks of cultural desire are caring, love, sacrifice, social justice[15], compassion, and encouragement (Campinha-Bacote, 2008). Cultural desire is purported to be learnt over a lifetime, with willingness to be open and flexible (Briscoe, 2013). This study showed that midwives had an open approach and compassion for migrant women, articulating their concerns about the inadequate provision of antenatal care, alluding to social justice. Midwives indicated that they wanted to care for migrant women, with some midwives working in case loading teams that catered specifically for migrant women. However, midwives did not clearly verbalise that cultural desire was an element of cultural competency. Midwives are required by statute to adhere to the NMC code and prioritise people which sets the foundation for the need to have cultural desire (NMC, 2018). However, cultural desire can be impacted by personal and organisational factors, as demonstrated by midwives in this study who reported that workload and staff shortages were demotivating. Affective constructs such as desire is stated to be difficult to quantify or evaluate (Campinha-Bacote, 2002). This study goes some way in suggesting that some aspects of cultural desire can be tactile and visible. However, midwives understanding of the importance of cultural desire for culturally competent care was not explicit.

Mothers described midwives' actions that could be construed as cultural desire, such as respectfulness, shared decision making and being listened to. These were important acts for mothers, as they viewed the midwife as wanting to provide antenatal care which was appreciated and welcomed. This study adds to the evidence, that cultural desire is important in interactions with women, as it is stated that clients do not care about how much you know, but how much you care (Campinha-Bacote, 2008). Mothers did not report disrespectful behaviour during their antenatal care which suggested midwives' desire to provide care. This contrasted to findings in other studies with migrant Black African women, Degni et al. (2014) stated that Somali women were subjected to unfriendliness from healthcare providers. Higginbottom et al. (2019), reported positive and negative relationships between migrant women and healthcare providers, where care, respect and open communication were discussed in contrast to rudeness and insensitivity. The current study contributes insights into midwives' perspectives of cultural desire, which is inherent and not recognised as a concrete skill but is displayed to women during antenatal care provision.

[15] Social justice- Fair and equitable division of resources and opportunities in society, including respect and rights of minorities.

Additionally, this study indicates that cultural desire arises from frequent contact with women from different cultures with implications for midwifery clinical practice.

6.8 Summary

This study's findings revealed four key concepts. Firstly, migrant Nigerian mothers are not asked about their culture during routine antenatal care provision and due to various factors, they protect or hide their culture. All mothers reported experiences that suggested that they received culturally competent care, however, these experiences did not fully reflect cultural awareness or cultural skill, two elements that are crucial in the achievement of cultural competency. The limited consideration of women's cultural needs meant that their quality of antenatal care was affected, this was mainly in relation to communication and information needs. This resulted in mothers seeking information from other venues. In addition, due to the lack of attention to culture, mothers' cultural expectations were not met. Cultural practices around pregnancy were rarely discussed during their antenatal care, either because a platform was not made available to do so or women chose to put their culture aside due to more pressing concerns around complications arising in pregnancy or pressures of being a new migrant. Several mothers explicitly or implicitly protected their culture, expressing no need to reveal any cultural practices. The reasons for this were various, such as unsureness of acceptable cultural practices in the UK or not wishing to share their culture with outsiders. However, if midwives had proficient cultural skill, some of these concerns would have been addressed. This study does not establish if lack of cultural skill was due to lack of training or experience, but there are important considerations for midwifery training. Some mothers' expectations of antenatal care contrasted to the reality, suggesting that care provided by midwives was inadequate. Midwives who had cultural knowledge would have been aware of pregnancy care in other countries and therefore, prepare mothers for antenatal care in the UK. This was particularly, relevant for mothers who had commenced antenatal care in Nigeria and had migrated to the UK during pregnancy, as it was highlighted that there were stark differences in antenatal care in Nigeria. Mothers did describe good examples of cultural awareness, knowledge, and skill during their antenatal care. It is uncertain whether this was coincidental or that the midwife had additional training or experience. Feeling safe, being asked permission, being given choice, and being treated kindly by midwives were considered by most mothers to be more important than midwives' cultural knowledge or encounters.

Secondly, mothers suggested that adjusting to living in the UK was prioritised over their cultural needs. The stress of migrating to the UK and seeking housing and employment were some of the issues revealed by mothers. Some mothers were aware of potential racism and discrimination in maternity services and were comforted by the presence of Black healthcare providers. There was sparse information in mothers' narratives of midwives discussing their migration journey or how they were adapting to living in the UK. Midwives who had sufficient encounters with migrant women would have been aware that there were stressors experienced by recent migrants. Another prominent issue was adapting to the English language, although all mothers spoke English with the majority (n=14) educated to University level, understanding complex medical or health advice was a challenge. In addition, it was assumed by midwives that English speaking migrant women understood conversations about medical conditions or interventions. Herein, midwives' cultural skill was inadequate in this aspect as miscommunication occurred leaving mothers frustrated and confused.

Thirdly, midwives were aware of what culturally competent care should consist of and were able to provide some aspects of this in routine antenatal care. Cultural awareness featured strongly in midwives' narratives, with discussions around unconscious bias, discrimination, racism, and stereotyping which occurred in other studies on midwives' experiences in caring for migrant African women. However, in contrast to other studies, midwives tried to mitigate this when providing care. The misconception of the 'strong Black woman' contributing to adverse pregnancy outcomes was a unique finding in this study, potentially due to the demographic of one focus group consisting of Black midwives. This implied that if the demographic of the focus groups had not included only Black midwives then this information may not have been revealed. Also, unique to this study was midwives' awareness of increased Black maternal mortality being explicitly conveyed to mothers in an attempt to improve their outcomes. Midwives also recognised the diversity of women, and in turn differences in their cultural practices and values. It was recognised that the midwives in this study were at an advantage as all had worked with a diverse population of women and therefore, had the benefit of cultural encounters. Unlike other studies, midwives did not view migrant Black African women as one homogenous group.

Midwives demonstrated the ability of cultural skill, and several tactics were used to perform culturally appropriate assessments during antenatal care. Midwives employed a range of methods, around communication skills such as listening and asking questions. An open approach was

articulated by several midwives as being a method that allowed women to share information. In addition, creating time was also described as being an important element for acquiring information. The cultural skill displayed by midwives in this study was not as evident with other studies with healthcare providers. No other studies highlighted culture desire as being valued by midwives, although it was alluded to in other studies where midwives wished to have training on cultural practices of Black African women. In this study midwives articulated words such as '*being receptive,' 'so, that I can learn and 'opening your mind.'* Demonstrating aspects of cultural desire, such as caring, understanding, and adapting care and showing justice.

Finally, midwives' ability to provide culturally competent care was impacted by societal, professional, and organisational issues. This was common in other studies, particularly around lack of interpretation services, stretched maternity services and conflicts with professional judgment. In this study, midwives revealed the nature of antenatal care provision in their Trusts and how services were not able to cope with the various needs of women. Midwives wanted to empower women, offer choice, and manage expectations but this was not always possible due to what the NHS was able to offer. Barriers to effective midwifery practice ranged from not being able to offer women if requested, female doctors or unable to provide an interpreter due to unavailability of a translator in the woman's dialect. Other impediments reported by midwives were family issues such as family gatekeepers preventing access for women, this point did not feature frequently in other studies.

The final chapter of this thesis will provide the recommendations as a result of this study for antenatal care providers and maternity services as a whole. Suggestions for future midwifery clinical practice and midwifery training will be made. Implications of this study's finding for professional regulation are considered. Required changes to national clinical maternity care guidance and maternal mortality reviews are set out and recommendations for future research are discussed and examined.

Chapter 7: Conclusion

This study discloses migrant Nigerian mothers' and midwives' perceptions of cultural competency in antenatal care. The setting was two NHS hospitals in two London boroughs which catered for a diverse child-bearing population. At the time of this study maternity units in England presented a picture of a service and workforce under an enormous amount of pressure (Brader, 2024). Maternal mortality reports also reported continued racial disparities for Black women with no significant improvements in maternal deaths in the last few years (Knight et al., 2023). This chapter draws together the findings and conclusions of this study and how this adds to the existing evidence. This is the first study that provides a unique contribution to knowledge on the perceptions of cultural competency in antenatal care which can be applied to other professional disciplines and educational platforms. My experiences as a Black woman, midwife, and an academic set my distinctive position as both an insider and outsider during this study. Therefore, my reflections were kaleidoscopic, acknowledging differences and variances of mothers and midwives in the context of society, the midwifery profession and academia. The findings from this study reveal the complexity of antenatal care experienced by migrant Nigerian mothers and how their cultural values are accommodated. Importantly, this study provides evidence that midwives face a spectrum of challenges that influence how they deliver culturally competent care during the antenatal period. Furthermore, my findings show the complex nature of cultural awareness, cultural sensitivity, cultural skill, cultural knowledge, cultural encounters, and cultural desire which are mired by personal, professional, and social aspects creating different stances on how this is perceived or executed. This study makes these processes more transparent and adds to the knowledge of providing antenatal services that at the least facilitates the cultural values and preferences of migrant Black African women.

7.1 Contribution to existing knowledge

This research advances the knowledge on migrant Black African women's experiences of antenatal care and midwives' experiences of providing antenatal care to migrant mothers in the UK, with a particular focus on cultural competency. The research questions were:

1. How do the perceptions of migrant Nigerian women differ from midwives' perceptions of cultural competency in antenatal care.

2. What are the cultural needs of migrant Nigerian women and how are their needs currently addressed within antenatal care provision in the NHS?

7.2 Importance of cultural competency in routine antenatal care

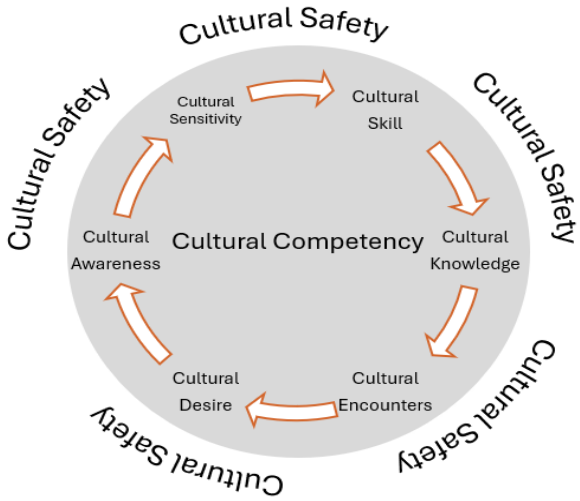
The models of cultural competency utilised in this study were developed by Campinha-Bacote (2002) and Papadopoulos et al. (1998), which incorporates the components of cultural awareness, cultural sensitivity, cultural skill, cultural knowledge, cultural encounters, and cultural desire. The different and various meanings of each component of cultural competency can cause misunderstanding of what this entails. Understanding of these concepts is the first step in becoming culturally competent. There are reports that allude to lack of cultural competency in maternity care provision leading to poor pregnancy experiences and outcomes (Knight et al., 2021, 2022, 2023). Culturally competent care is recognised in the literature with government healthcare policies advocating for culturally sensitive care. Policies, guidance, and reports that are specific to maternity care advise on the need to be inclusive and consider the needs of a diverse childbearing population (Knight et al., 2023; NHS England, 2016; RCOG, 2008). This study promotes this work, by emphasising that cultural competency is an essential element of antenatal care provision. This study reveals the ability of midwives to provide culturally competent care and how this is suited to the needs of migrant Black African women. The contrast between the perceptions of migrant Black African women and midwives illuminates the differences that need to be addressed in antenatal care. Other studies have highlighted the needs of migrant Black African women when engaging with maternity care and the challenges faced by healthcare providers which mirrors some of the findings in this study. This study confirms that cultural competency is perceived differently by mothers and midwives, leading to gaps and reduced quality in care provision. It is established that midwives' application of cultural competency to clinical practice requires attention to all the components to achieve proficiency.

7.3 Midwives' recognition of culturally competent antenatal care

This study confirms that midwives' perceptions of cultural competency are explicit regarding cultural awareness, cultural sensitivity, cultural skill, and cultural knowledge and more implicit in relation to cultural encounters and cultural desire. Cultural safety was not discussed by midwives, showing unawareness of this concept. Uniquely, midwives' acknowledgment of women's needs

was evident in this study, showing that cultural safety was inherently practiced. Midwives do not see migrant African women as one homogenous group and do not expect them to adapt to UK culture, which contrasted with other studies (Degni et al., 2014; Shorey et al., 2021; Tobin & Murphy- Lawless, 2014). As found in other studies, there are personal and professional issues that can impact on midwives' ability to provide culturally competent care, ranging from unconscious bias, conflicts with professional judgement and accountability. In addition, organisational factors impinge on midwives' ability to conduct culturally competent care, such as lack of interpretation services, non-availability of gender specific staff, increased workload, and staff shortages. The utilisation of cultural skill was not alluded to in many studies, however in this study, midwives recognised the need to undertake culturally appropriate assessments. I believe that my questioning during the focus groups enabled midwives to convey attributes of cultural skill, albeit instinctively. The benefits of cultural encounters and desire were also limited in other studies, whereas in this study midwives demonstrated how this influenced their ability to provide culturally competent care. In this study care, compassion, listening to women and showing justice was described by midwives, all attributes of cultural desire. Cultural safety is confirmed as an essential element in antenatal care provision and deemed to be more effective than cultural competency (Lokugamage et al., 2023; Ramsden, 2002). However, this study suggests that the constructs of cultural competency: awareness, sensitivity, skills, knowledge, encounters, and desire are needed to boost cultural safety. It is argued that the construct of cultural competency is the core of cultural safety (see figure 12 1).

Figure 12 1: Cultural Competency as a core of Cultural Safety



7.4 Cultural connection between migrant mothers and midwives

This study shows that mothers perceived midwives

as being there to cater for their physical needs rather than their cultural needs. Suggesting that mothers determined if they wished to share their culture with midwives. Mothers who were pregnant for the first time in the UK or who had migrated to the UK during pregnancy revealed that discussion of their culture would have been beneficial to their pregnancy care which was a prevalent finding in other studies. Other mothers did not wish to discuss their cultural values or did not see the benefit of this during their antenatal care. This contrasted with other studies where migrant Black African women wished for their culture to be accepted as an integral part of their pregnancy care. This study did not explicitly reveal the cultural clashes found in other studies. However, some lack of connection between mothers and midwives was exposed in this study which echoed findings in other studies. Mothers stated that cultural knowledge was not expected from midwives, rather that being kind and responsive to their needs were more important. Other concerns raised by mothers were difficulties in accessing and engaging with antenatal care such as prolonged referral processes, long waiting times, short appointments, and communication issues. Access to antenatal care was raised as a frustrating issue by mothers in this study, which was not what they had expected in the UK, these findings are consistent with previous research. Mothers' perceptions of cultural competency in this study were individualised, highlighting the importance of midwives providing care based on a robust assessment of a woman's cultural needs.

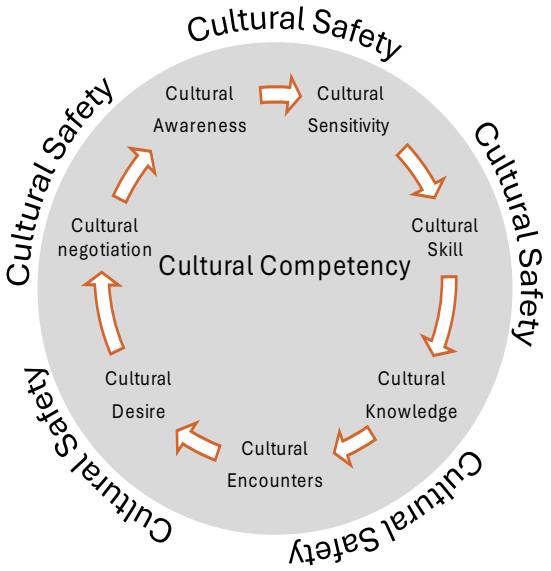
7.5 Unique contribution to knowledge

Cultural negotiations in antenatal care

Although this study's findings are compatible with other studies involving migrant Black African mothers and midwives who have cared for migrant women, there are several areas in which they differ. The principles of cultural competency state that being aware that a person has a different culture to the healthcare provider is a fundamental element. In this study midwives embraced and wanted to facilitate women's cultural values but found themselves caught between their personal culture, professional culture, and organisational culture, in other words a cultural limbo. Therefore, their ability to practice cultural competency varied on a day-to-day basis. My research reveals cases when this occurred and how midwives dealt with and negotiated these instances. These experiences created daily dilemmas for midwives, wishing to demonstrate cultural competency during antenatal care. Cultural competency as a concrete concept was articulated by midwives but

the application of this in practice was influenced by professional judgement and organisational policy. Cultural skill was impacted by time given for antenatal appointments, language barriers, and increased workload. Therefore, midwives adopted strategies that accommodated the needs of women, but routine antenatal care took precedence over any cultural requirements. Therefore, it is argued that another construct is required in the achievement of cultural competency, that of cultural negotiation (see figure 13 1).

Figure 13 1: Cultural negotiation as an additional construct to cultural competency



In the context of the present study, cultural negotiation is defined as provision of care that is balanced between the culture of the care provider and the care receiver, and influenced by external factors, such as organisational policy and professional codes of conduct. Therefore, the different perspectives of culture are in equilibrium and meets the needs and desires of all participants involved in that care episode. The instances where midwives juggled their personal and professional culture, and the culture of the woman led to the need to negotiate the care provided. This included midwives' consideration of women's cultural practices, language and

communication needs and meeting their expectations of pregnancy care. Professional accountability and the autonomous nature of the midwife's role resulted in an ability to adjust care and offer alternatives if there was conflict with the woman's wishes and desires. Furthermore, although organisational policy was adhered to by midwives, if there was potential conflict with the women's wishes regarding her care, these were prioritised and additional support from midwifery management and obstetric input was sought if required.

The ability to undertake cultural negotiation was dependent on the experience of the midwife, and the ability to be culturally aware and sensitive. These constructs facilitated the exploration of women's needs and an understanding of nuances of how this varied between individuals. Hence, midwives were able to acknowledge the specific cultural needs and values that women desired to be maintained. In addition, cultural skill, cultural knowledge, and the benefits of cultural encounters and cultural desire were other constructs utilised to undertake cultural negotiation effectively. Cultural skill was undertaken by midwives to assess women's needs, and this was facilitated by cultural knowledge which provided a platform for the sharing of information. Cultural negotiation was strengthened by cultural encounters and cultural desire, as these constructs provided experience with and motivation to care for women from different backgrounds. Therefore, it is stated that the other constructs of cultural competency are needed to undertake cultural negotiation.

Migrant pregnant women are not asked about their culture

The contrast between migrant mothers' and midwives' perceptions of cultural competency in antenatal care revealed remarkable insights on how this concept was received and delivered in the NHS. This study offers new evidence that women are not routinely asked about their culture during antenatal care. It was apparent that midwives were unconscious that their exploration of women's culture was superficial. Therefore, there was a mismatch between the views of mothers and midwives. Similar to other studies where cultural practices of migrant Black African women were explored (Dike, 2019; Goberna- Tricas et al., 2005; Hill et al., 2012; Sarantaki et al., 2020), this study identified a gap between the woman perceiving that the midwife was culturally competent and midwives perceiving that they were providing culturally competent care. Some mothers justified this omission from midwives, providing views that it would be apparent that midwives would be aware that they had a different culture. However, these omissions meant a lost

opportunity for midwives to refine the process of cultural awareness, the starting point for cultural competency (Campinha-Bacote, 2002) and deepening critical awareness to achieve cultural safety (Ramsden, 2002).

Culture is hidden or protected by migrant women during pregnancy

Migrant Nigerian mothers in this study described experiences comparable to other studies revealing that they put aside their culture to adapt to a new country and a new healthcare system. This setting aside of culture was due to mothers wishing to integrate into UK culture. Mothers alluded to protecting their culture or not wishing to expose their culture to avoid the casting of any aspersions on their values or unsurety of lawful cultural practices. Hence, like midwives, migrant mothers also experienced cultural limbo. Ola discussed how she did not wish to expose her culture but still desired to have some cultural practices followed in her pregnancy. In hindsight, this resulted in Ola not preserving a cultural practice in pregnancy that had been adhered to in previous pregnancies whilst in Nigeria. Mothers also mourned the loss of community support and not being able to share their pregnancy journey with other mothers as a cultural expectation for antenatal care. Temi spoke of antenatal classes where singing and dancing with other pregnant women occurred in Nigeria and had looked forward to similar opportunities in the UK. Although similar events may not occur in the UK, antenatal classes would have met some mothers' needs. This is a void that could have been circumvented by either the mother sharing her culture or being asked about any cultural values or expectations by the midwife. Omission of cultural discussions by midwives potentially led to the woman's culture not having a place in routine antenatal care.

7.6 Unexpected findings

The misconception of the 'strong Black woman,' although already present in the literature was bought to the forefront in this study as a potential unseen barrier to culturally competent care. The term, 'strong Black woman,' was described by midwives as a Black woman being expected to endure physical and emotional pain and to get on with her pregnancy even in the face of poor-quality care. The Black Maternity Experiences Survey conducted in the UK, also reported the misconception of the 'strong Black woman' (Peter & Wheeler, 2022). The misconception of the 'strong Black woman,' has also been highlighted in American studies, a legacy from the Transatlantic slave trade (Liao et al., 2020). Significantly, in this study it was highlighted by midwives that this misconception needed to be exposed, broken down and discarded, as they believed that the perpetuation of this belief was dangerous and harmful to Black mothers. Hence,

midwives attempted to mitigate potential harm caused by this misconception by forewarning Black mothers and explicitly divulging their risks of increased maternal mortality in the UK. This study unexpectedly highlighted that midwives believed that further protection was needed for Black pregnant women which could not be accommodated by current antenatal care provision. Midwives suggested that in the current climate of racial disparities, discrimination, and racism, Black pregnant women needed to be forearmed against the potential of becoming another maternal mortality statistic. Therefore, the midwife became an activist for human rights in the provision of routine antenatal care, adding an additional layer to their role as an advocate and educator.

7.7 Limitations

Methodology

A qualitative descriptive approach was adopted for this study, which is not recognised as a robust research methodology (Ellis & Hart, 2023). The use of a qualitative descriptive approach may be queried as the right methodology for this study. However, the requirement to focus on the perceptions of cultural competency in this study meant that other qualitative methodologies such as phenomenology, ethnography, and grounded theory would be inappropriate. Critics have claimed that a qualitative descriptive approach makes for atheoretical research (Neergaard et al., 2009). Nevertheless, a qualitative descriptive approach draws on the strength of established methodologies but maintains flexibility in the methods and data analysis (Kahlke, 2014). During the design of this study, there was difficulty in fitting my research questions into known and accepted methodologies and I felt that in doing so I would restrict my ability to explore the phenomenon in detail. Furthermore, research questions should drive the methodology rather than vice versa (Caelli et al., 2003; Kahlke, 2014). I challenged the Eurocentric view that research must fit certain methodologies, when there are other ways of knowing which may be Indigenous, and non-Western. It is stated that researchers are compelled to subscribe to a Eurocentric view when designing studies and are suppressed by the need to adhere to methodological prescriptions (Sandelowski, 2000). This can lead to a poorly designed study which becomes the poor relative of good qualitative research. Justification has been provided for the utilisation of a qualitative descriptive approach; this has been defended in this study by stating my ontological and epidemiological stance (see chapter 3).

Conventional content analysis was used in this study, to remain close to the data, and allow codes to be generated using the raw data (Hsieh & Shannon, 2005). Using a conventional content

analysis approach would meet with some query as the common approach in qualitative methodologies is thematic analysis. Thematic analysis was not appropriate for this study on Black African women's perceptions as there could be loss of the nuances of their discussions. I was cognisant of the differences in cultural linguistics and verbal expressions from individuals who spoke English as a second language. Conventional content analysis facilitated the creation of content characteristic codes, categories and themes, maintaining the diverse views and expressions of the mothers and midwives in this study. This differs to thematic analysis where initial codes are generated by interesting features in the data and by searching for themes (Braun & Clarke, 2022). Using conventional content analysis, I was able to remain objective and extract the meaning of participants' responses (Hsieh & Shannon, 2005).

Data collection

A few of the interviews with mothers (n=4), had data missing due to poor quality recordings. However, the questions I asked during the interviews were clearly recorded. Notes were made for each of the interviews and most of the mothers' responses were documented, albeit not in detail, as I used paraphrasing throughout each interview. Another issue was that most of the interviews (n=14), were conducted by telephone, hence there were no visual observations taken which may have limited the analytical possibilities. The one interview which was done face to face demonstrated the additional information that could be acquired such as body language. I was unable to make any assumptions about eye contact or facial expressions during the telephone interviews, which would have contributed to the data collected. Limited observations of midwives' body language occurred in the focus groups. Although, as the platform used was MS teams, some participants joined the meeting with their camera on, so some body language was observed. Furthermore, due to time limitations of part time PhD studies more time could have been taken between interviews and transcribing data to allow space to reflect over the meetings. This would have provided further insight when conducting future interviews, allowing for deeper exploration of concepts already retrieved.

Bias

There was a possibility of bias in my position as a Black African mother, who had experience of living in Africa and giving birth in the UK. Therefore, researcher bias was at the forefront of my engagement with this study. Maintaining a reflective diary and jotting down my thoughts was used to keep bias to a minimum. However, it was recognised that as a Black mother researching Black

mothers' experiences there was a potential to make assumptions about the responses received. I had anticipated that all the mothers would wish to have their culture considered in antenatal care, but this was the opposite. Documentation of these assumptions and how I attempted to avoid bias as an insider/outsider was contemplated to ensure that the study's findings were authentic. During the interviews I probed women and shared information from previous interviews to gauge how they would respond which is stated to be useful in reducing bias. Reflexivity was adopted throughout this study involving a critical examination of my role, biases, and assumptions. In this way readers could consider the influences of my own perspectives during the conduct of this study (Lincoln & Guba, 1986). There is a possibility that if this research had been conducted by an individual who did not share the same ethnicity as the women, the findings may have been different. However, subjectivity is always an issue with researchers, and hence, it is important to acknowledge this. My Black ethnicity was more likely to be an advantage than a disadvantage since this commonality led to a deeper discussion with the Nigerian mothers and a shared understanding of some of their experiences. Researchers from non-Black ethnicities have researched Black populations and there are advantages and disadvantages, such as limited preconceived ideas and lack of insider knowledge. The same issues concerning bias could also be applied to my role as a midwife researching midwives, as the sharing of the same professional values and antenatal care experiences could also influence my interpretation of their discussions, but also positively impact my analytical skills. Therefore, there are arguments for and against bias regardless of the researcher's background, so my stance was to carefully consider my insider/outsider perspectives throughout this study.

Transferability

The findings of this study are restricted to migrant Black African women from Nigeria so they may not be applicable to other migrant Black African women. Although, findings such as migration experience and perspectives of antenatal care may be transferable. Culture is multidimensional and constructed by social and environmental factors which limits the findings of this study as individuals will have differing perceptions of culture. Rich and thick descriptions have been provided in the findings (see chapters 4 and 5). This assists in an independent review of the data and an ability for readers to make their own conclusions (Tenny et al., 2022). The midwives in this study worked in two areas of London, therefore they had opportunities to encounter a diverse child-bearing population. Hence, the findings from this study may not be applicable to other areas in the UK, where midwives do not care for women with different cultures. Nevertheless, knowledge from this study is relevant in any context where there is a population of migrant pregnant women.

The mothers in this study were from two tribes in Nigeria, Yoruba and Igbo, and so did not include women who spoke other languages which account for 0.06% of migrant Nigerians in England. This should be considered when examining the findings as mothers' views in this study may not reflect migrant Nigerian women from other tribes. According to the ONS, 67.8% of Nigerian migrants in the UK have a higher education qualification (ONS, 2023). In the present study, 86% of the Nigerian mothers had completed tertiary education, hence there was a 18% higher representation of women with tertiary education in the sample, which should be considered when reviewing the study's findings.

7.8 Recommendations

Midwifery clinical practice

This study shows that migrant Black African women's opinions differ in the importance they placed on cultural competency in antenatal care. The migrant mothers navigated through pregnancy with limited attention paid to their culture, however some mothers would have preferred midwives to pay some interest in their cultural values. In contrast, midwives attempted to deliver what they perceived to be culturally competent care to migrant mothers but were limited by internal and external factors. To balance this dissonance between mothers' needs and midwives' ability, a more focused approach on cultural competency in antenatal care is required. The booking interview is usually the first contact that mothers have with midwives and is a risk assessment undertaken to plan the mother's pregnancy care (NICE, 2021). This risk assessment involves a series of questions exploring the woman's obstetric, medical, and familial history as well as confirming her demographics including educational status, employment, and country of birth. A physical assessment is also undertaken, including screening blood tests. Midwives demonstrated attributes of culturally skilled assessments in this study, but this was impacted by time limitations, workload, and language barriers. To facilitate cultural skill, it is proposed that increased time is allowed for the booking interview to allow for a cultural assessment of the woman. It is suggested that this cultural assessment should be repeated after twenty-eight weeks gestation to facilitate the creation of a birth plan. This study shows that antenatal classes were not offered to migrant mothers resulting in feelings of isolation and exclusion from the pregnant community. Antenatal classes should be offered to all migrant women regardless of their parity. In areas where there is a high population of migrant women, provision should be made to arrange tailored antenatal classes that provides culturally relevant information and interpretation services if needed.

Post registration education

Cultural competency training is not a routine part of midwifery mandatory training in maternity units, although some midwives in this study had undertaken unconscious bias training. This study shows deficits in midwives' cultural competency, and it is strongly recommended that mandatory training on the constructs of cultural awareness, cultural knowledge, and cultural skill is provided. In addition, the concepts of cultural safety should be covered in training to ensure that midwives are aware that it is the women who determines if care provided is culturally appropriate. Other staff who participate in providing care in maternity units should be subjected to this training. Maternal mortality reports have recommended that healthcare professionals who work together should train together regarding obstetric emergencies as this strengthens communication and collaboration (Knight et al., 2023). This thesis has highlighted midwives' conflict between professional culture, organisational culture, and the woman's culture, hence shared training with other healthcare professionals on cultural competency can assist in reducing such conflict.

Professional regulation

The midwifery profession is regulated by the NMC, and the code of professional conduct provides the rules and values that are expected to be upheld (NMC, 2018). A recent NMC review reported racism and discrimination and a toxic culture impacting on safeguarding decisions (Afzal & Rise Associates, 2024). An additional theme to protect cultural values is essential. Cultural competency and cultural safety should be a thread through the NMC code of professional conduct, which will ensure that higher education institutes and maternity care providers reflect this component in their curriculums and policies.

In the standards of proficiency for midwives, consideration of the woman's culture is limited (NMC, 2019). It is proposed that greater emphasis on facilitating cultural values and norms in these standards is necessary. In domain six, cultural competence is stated as being a requirement for effective care and different cultural contexts and traditions should be taken into consideration (NMC, 2019). To heighten awareness of the importance of cultural competency and cultural safety in midwifery practice and to cater for women from different cultures, it is suggested that a separate domain is required. This domain should include the constructs of cultural competency and the requisites of cultural safety.

Preregistration midwifery education

Cultural awareness is stated to be the starting point of cultural competency (Campinha-Bacote, 2002), and cultural safety is the critical awareness of one's own culture (Ramsden, 2002). The future midwifery workforce should enter the profession with cultural awareness as a requisite skill acquired during training. In the standards for preregistration midwifery education, it is stipulated that students are exposed to learning opportunities to develop required skills to care for women with additional needs taking into consideration cultural factors (NMC, 2023). However, there are no other references to culture or cultural competency within these standards. Hence, an addition to these standards is recommended to incorporate and strengthen the position of cultural competency in midwifery education. Midwifery education providers should address this deficiency within midwifery curriculums. Modules should include cultural competency and cultural safety in the indicative content to ensure delivery of these concepts throughout midwifery training. Furthermore, theoretical assessments should include aspects of cultural competency and cultural safety to assess students' knowledge on how these are applied in practice. Another recommendation relates to clinical placements and how midwifery students are assessed regarding cultural competency. The current midwifery practice document used to assess midwifery students in clinical placement in England includes proficiencies related to antenatal, intrapartum, postnatal, and neonatal care with an additional cluster for promoting excellence. To strengthen the assessment for cultural competency, an additional element is recommended, that students have experience of undertaking cultural assessments of women as part of their training. Such cultural assessments should consist of a review of the woman's cultural beliefs, values and practices and the impact of these on pregnancy, childbirth, and the baby. This will support cultural encounters which will strengthen cultural skill and desire in students if cultural assessments are mandatory proficiencies during preregistration midwifery training.

Maternal Mortality reports and National clinical guidelines recommendations

Yearly maternal mortality reports in their review of any maternal death should undertake a cultural review when conducting confidential enquiries. It is suggested that information sought from all clinical staff that were involved in women's care should include perspectives on any cultural factors during care provision. This is relevant as ethnicity is independently associated with a maternal death (Knight et al., 2023). Awareness of cultural stigmas and the need for healthcare professionals to appropriately assess individuals from different cultures have been advised to

reduce maternal mortality (Knight et al., 2022). Cultural biases have led to women not receiving essential pregnancy advice, leading to maternal mortality report's recommendations to address these issues through midwifery training (Knight et al., 2021). However, maternal mortality reports must pinpoint the issues rather than just alluding to these by undertaking a robust cultural assessment of each maternal death. This cultural assessment will provide necessary information that can inform midwifery training, and national and organisational policies.

NICE guidance on antenatal care supports the need for exploring social, medical, and psychological issues with women (NICE, 2021). Cultural issues are not mentioned in the antenatal care guidance, showing a gap in addressing this aspect of women's needs. NICE stipulates offering longer antenatal appointments for recent migrants and for women who may need further support. A review of cultural values should also be included in antenatal care guidance to improve holistic care for women. NICE (2021), recommends the consideration of the woman's home and family situation and available support during antenatal care, all of which can be impacted by cultural values. An assessment of cultural values should also be included in intrapartum and postnatal guidance so that culturally appropriate care is provided throughout the woman's pregnancy and childbirth journey.

Care Quality Commission recommendations

Maternity services regulation conducted by the CQC should include a detailed review of culturally competent resources and policies available to staff. The review should also include whether culturally appropriate assessments for mothers and babies are incorporated in Trust clinical guidelines. There should be a clear review of interpretation services and how these are accessed by midwives, and how women's English proficiency is assessed during pregnancy care. Review of mandatory training for midwives and other maternity healthcare professionals should be examined to see if a cultural competency element is provided. Maternity healthcare professionals including students should be interviewed during CQC inspections on their understanding of cultural competency and how the needs of women are addressed during pregnancy care. Reviews of maternity services by the regulator should include women and families being asked if their cultural values were respected.

Research

This study has already discussed the issue of Eurocentric methodologies that influence how researchers conduct research. It is recommended that different ways of knowing need to be recognised by higher education institutes and the incorporation of non-Western and Indigenous approaches to research. Adopting culturally sensitive methodologies should not include the abandonment of Western research approaches, however, there should be some adjustment so that barriers are overcome between researcher, participants, and the communities where the research is planned to take place (Datta, 2018). Western research training governs the way in which researchers engage in research studies and there is limited culturally appropriate research training, which could lead to inappropriate research methods being used with diverse populations (Datta, 2018). Therefore, it is recommended that research funders and ethics panels should make it mandatory that research proposals include a cultural sensitivity assessment.

Qualitative studies should be undertaken to explore migrant Black African women's cultural values and needs during pregnancy. Focus groups or interviews are appropriate methods to examine the extent to which this guides women's health seeking behaviour during pregnancy. An exploration of the religious and spiritual values of migrant Black African women are other perspectives that will be useful to investigate to provide a holistic representation of women's experiences. Research that focuses on cultural competency in intrapartum and postnatal experiences of migrant Black African women is required to provide a full picture of the whole pregnancy continuum. The present study focused on recently migrant mothers' perceptions of cultural competency during antenatal care but revealed some important aspects of their intrapartum and postnatal experiences. In particular, investigation into how their perceptions influenced their engagement with intrapartum and postnatal care will provide further insight into how maternity care provision facilitated their needs during this period. This is also relevant as maternity mortality is more likely to occur in the postnatal period, so mothers' experiences will enrichen the available data in this area. In addition, further studies are required to confirm this study's results with a more diverse sample of migrant Black African women and midwives from maternity care providers across the UK.

The misconception of the 'strong Black woman' was an unexpected finding in this study, future research can extend this work, to ascertain how this is perceived within the midwifery workforce, so that findings can be utilised to raise awareness. Further research on the organisational factors that impact on midwives' cultural competency will provide useful information for maternity services.

Research should focus on resources available to care for the various needs of migrant women and how this is delivered within maternity units across the UK (Igbineweka et al., 2021). Inclusion of research with other health care professionals who deliver maternity care will provide a depiction of the multidisciplinary care that women receive in the UK. The role of family is an important consideration in a woman's pregnancy and research into this sphere will provide vital information to midwives. There are cultural norms in the role that partners and family play in a woman's pregnancy, studies with fathers, couples and families will provide information to inform current maternity care provision.

Research that explores how midwives undertake the construct of cultural negotiation and the factors that hinder or promote this is required. Highlighting the present of cultural negotiation in midwifery practice will provide information that can be utilised to strengthen the value of this construct in the provision of culturally competent care. Furthermore, focus on how cultural negotiation occurs between midwives and other members of the multidisciplinary team in maternity services will provide insight into how professional culture impacts on the ability to accommodate a woman's culture. Research on women's perspective of cultural negotiation would also be relevant, to provide an emic view of these interactions and how these meet their cultural needs.

7.9 Dissemination

It is recommended that preferred methods for dissemination for underrepresented groups such as community meetings, newsletters and social media is undertaken (Erves et al., 2017). Recognition of the contributions that communities make to research studies by increasing participation is a key component of culturally sensitive research (Rangel & Valdez, 2017). Therefore, researchers should provide summary reports to participants, soliciting feedback and demonstrating how the research findings may contribute to policy change. In addition, it is important to train community stakeholders in the interpretation of study results to avoid any misconceptions (Awad et al., 2016). This ensures the benefits of any research is understood by the communities who will benefit from any recommendations or interventions.

7.10 Autobiographical reflection

In undertaking this PhD study, I have gained an understanding of the nature of conducting research in real life contexts. I have learned that research is not a straightforward process, but rather a complex and intricate journey that requires motivation, passion, and hard work to reach a destination. During this PhD journey I have explored my professional and personal values and my previous experiences as a midwife and current experiences as an academic. On reflection my stance as a midwife academic has changed from one of pragmatism to activism. Stagnant and unsuitable services that do not cater for the unresearched are socially unjust. I have realised that speaking against these injustices is needed rather than waiting for others to step forward. However, a voice alone is not enough to balance inequalities, I have realised that use of research evidence means that the researched voices are listened to.

7.11 Research influence

I started this PhD as a personal ambition to highlight the outcomes of Black women during pregnancy and particularly the improvements needed in routine antenatal care provision. I took the decision to self-fund my studies as my research topic was not of particular interest to funders and waiting for a funded PhD in my area of interest may not have materialised. In my experiences as a caseload midwife to high-risk Black women, I understood the contribution of holistic care to a positive and safe pregnancy journey. The mothers' voices revealed in this study are real and relevant and should be believed. The midwives' views that demonstrated a commitment to provide good quality care to migrant Black women show their perseverance and strength. I have learned from the mothers and midwives in this study that there are numerous issues in the NHS and courage and motivation is necessary to share and learn from each other to overcome the predicament of ongoing racial disparities in pregnancy.

I have disseminated my work across national and international platforms through research conferences, seminars, and publications (see appendix 11 and 12). I have been invited to speak on issues related to racial disparities to a worldwide audience, including the Maternity and Midwifery hour and the Society of Afro Caribbean midwives and nurses. I have published widely on racial disparities in pregnancy including a textbook on Transcultural Midwifery Practice which provides knowledge of caring for a diverse childbearing population. I have also produced work on decolonisation of midwifery curriculums and cultural safety in midwifery education. I am an expert adviser for a study with the University of Oxford concerned with improving outcomes in the

postnatal care for ethnic minority mothers. I am currently a committee member for a national Research Prioritisation Setting Project with the Royal College of Midwives and sit on the Stakeholder committee for the NHS Maternity and Neonatal transformation programme.

7.12 Conclusion

A qualitative descriptive study was undertaken using one-to-one interviews with migrant Nigerian women and focus groups with midwives to explore their perceptions of cultural competency in antenatal care. This study is unique in its focus on cultural competency and adds to the landscape on migrant Black African women's pregnancy needs in the UK. The findings from this study show that midwives are aware of the importance of cultural competency in antenatal care but their ability to deliver such care is impacted by personal, professional, societal, and organisational factors. To meet women's cultural needs within these constraints, midwives continually undertake cultural negotiations. The unique finding of midwives forewarning and forearming mothers about Black maternal deaths, which was stated to be driven by the misconception of the 'strong Black woman' arose in this study. Revealing that midwives believe that routine antenatal care does not meet the needs of Black women, leading to personal activism in an attempt to reduce poorer pregnancy outcomes.

The mothers in this study provide a story of their cultural needs and values during pregnancy and how they perceived their antenatal care. This study revealed that migrant Black African women are not routinely asked about their cultural needs during pregnancy. This differed to midwives' views who reported that they were culturally aware of the differences in the women they cared for, however they were not explicit in asking women about their cultural values. The mothers' desire to hide or protect their culture during their antenatal care meant that unless explicitly asked about their culture, this would not be considered in their antenatal care. The differences in mothers' responses demonstrate that they are not a homogenous group, and their cultural values are distinct.

This study shows that midwives need to undertake training that broadens their knowledge of cultural competency. The constructs of cultural competency: cultural awareness, cultural sensitivity, cultural skill, cultural knowledge, cultural encounters, and cultural desire needs to be explored with midwives to develop their abilities in caring for women from other cultures. It is

argued that further training on cultural competency should be incorporated into yearly mandatory training for midwives. This thesis highlights that lack of cultural competency can lead to stereotyping and unconscious bias and to mitigate these occurrences, midwives should reflect regularly on how this influences their daily practice.

To strengthen culturally competent practice, routine antenatal care provision should include a cultural assessment to ensure that cultural values and needs are part of the woman's plan of antenatal care. It is suggested that this provision will allow women, to convey their cultural needs in a safe environment if they wish to do so. Maternity unit policies should stipulate that midwives assess women who are recent migrants and provide support by way of a schedule of antenatal care that addresses their social, cultural, spiritual, and psychological needs.

This study argues that there is a paucity of regulation pertaining to cultural competency in healthcare in the UK. Currently, the NMC code of professional conduct does not explicitly discuss cultural competency, their standards for professional conduct should cater more fully for the culturally diverse population in the UK. More focus on advocating for cultural needs in the NMC code will assist healthcare organisations and higher education institutes to incorporate cultural competency into their policies and curriculums. The limited attention paid to healthcare professionals' cultural competency can begin to be addressed and included as a necessary rather than a desirable skill, similar to NMC regulation in New Zealand and Australia.

This thesis suggests that midwifery preregistration education requires a focus on equipping students to be culturally aware and to understand how to care for women in current NHS provision. Students should be exposed to the culturally diverse childbearing population of the UK and know how to negotiate effective quality pregnancy care. Explicit incorporation of cultural competency in the standards for midwifery education will provide a platform for midwifery training programme providers to address this in their delivery of midwifery curriculums.

Finally, this study has met the aims of adding to the body of knowledge on migrant Black women's cultural needs during routine antenatal care provision and confirms that their expectations are not fully met. The voices of the migrant Black African mothers have been given a platform in this study and reveals the difficulties they encountered during their antenatal care. Unfortunately, the voices

of the migrant Black mothers who died are unattainable, but some of their views may have been similar to the mothers in this study. A new understanding of the role of the midwife as a cultural negotiator and activist for reducing maternal mortality for migrant Black women has emerged in this study and has implications for the future of midwifery practice. The incredible and far-reaching activities that midwives undertake to meet women's antenatal needs are applauded and I have admiration for the tenacity they have shown in the face of their challenges. This thesis' findings have important implications for maternal mortality review panels, policy makers and healthcare regulators who must be more invested in creating equitable maternity services and have targeted actions to address the cultural barriers that lead to racial disparities. Research that targets migrant Black African women's pregnancy needs must be undertaken, and interventions developed and assessed to determine the best approaches that can reduce adverse pregnancy outcomes. In doing so, the needs of migrant Black African women will be considered in the delivery of maternity care.

References

Abebe, H., Beyene, G. A., & Mulat, B. S. (2021). Harmful cultural practices during perinatal period and associated factors among women of childbearing age in Southern Ethiopia: Community based cross-sectional study. PLoS One, 16(7), e0254095.

Abdulla, M. R. (2018). Culture, religion, and freedom of religion or belief. The Review of Faith & International Affairs, 16(4), 102-115.

Adams, J., Hillier-Brown, F. C., Moore, H. J., Lake, A. A., Araujo-Soares, V., White, M., & Summerbell, C. (2016). Searching and synthesising ‘grey literature ‘and ‘grey information ‘in public health: critical reflections on three case studies. Systematic reviews, 5, 1-11.

Aderibigbe, I. S. (2015). Religious traditions in Africa: An overview of origins, basic beliefs, and practices. Contemporary perspectives on religions in Africa and the African diaspora, 7-29.

Adler, K., Salanterä, S., & Zumstein-Shaha, M. (2019). Focus group interviews in child, youth, and parent research: an integrative literature review. International Journal of Qualitative Methods, 18, 1609406919887274.

Adler, R. H. (2022). Trustworthiness in qualitative research. Journal of Human Lactation, 38(4), 598-602.

Afzal, N & Rise Associates (2024). NMC Independent culture review https://www.nmc.org.uk/globalassets/sitedocuments/independent-reviews/2024/nmc-independent-culture-review-july-2024.pdf

Ahern, K. J. (1999). Ten tips for reflexive bracketing. Qualitative health research, 9(3), 407-411.

Ahmadinia, H., Eriksson-Backa, K., & Nikou, S. (2022). Health-seeking behaviours of immigrants, asylum seekers and refugees in Europe: a systematic review of peer-reviewed articles. Journal of Documentation, 78(7), 18-41.

Ahmed, S. K. (2024). The pillars of trustworthiness in qualitative research. Journal of Medicine, Surgery, and Public Health, 100051.

Akbulut, N., & Razum, O. (2022). Why Othering should be considered in research on health inequalities: Theoretical perspectives and research needs. SSM-population health, 20, 101286.

Albougami, A. S., Pounds, K. G., & Alotaibi, J. S. (2016). Comparison of four cultural competence models in transcultural nursing: A discussion paper. International Archives of Nursing and Health Care, 2(4), 1-5.

Allen, K. A., Charpentier, V., Hendrickson, M. A., Kessler, M., Gotlieb, R., Marmet, J., ... & Pitt, M. B. (2023). Jargon be gone–patient preference in doctor communication. Journal of Patient Experience, 10, 23743735231158942.

Al-Saadi, H. (2014). Demystifying Ontology and Epistemology in research methods. Research gate, 1(1), 1-10.

Altuntuğ, K., Kiyak, S., & Ege, E. (2023). Relationship between birth memories and recall and perception of traumatic birth in women in the postpartum one-year period and affecting factors. Current Psychology, 1-9.

Anderson, C., & Kirkpatrick, S. (2016). Narrative interviewing. International Journal of Clinical Pharmacy. 631-634.

Applebaum, B. (2021). Ongoing challenges for White educators teaching White students about Whiteness. Studies in Philosophy and Education, 40(4), 429-441

Apuke, O. D. (2017). Quantitative research methods: A synopsis approach. Kuwait Chapter of Arabian Journal of Business and Management Review, 33(5471), 1-8.

Aquino M R J V, Edge D, Smith D M. 2015. Pregnancy as an ideal time for intervention to address the complex needs of Black and minority ethnic women: Views of British midwives. Midwifery. 31(3):373-379.

Archibald, M. M., Ambagtsheer, R. C., Casey, M. G., & Lawless, M. (2019). Using zoom videoconferencing for qualitative data collection: perceptions and experiences of researchers and participants. International journal of qualitative methods, 18, 1609406919874596.

Arshad, M., & Chung, J. M. (2022). Practical recommendations for considering culture, race, and ethnicity in personality psychology. Social and Personality Psychology Compass, 16(2), e12656.

Arundell, F., Mannix, J., Sheehan, A., & Peters, K. (2018). Workplace culture and the practice experience of midwifery students: A meta-synthesis. Journal of nursing management, 26(3), 302-313.

Atewologun, D., Cornish, T., & Tresh, F. (2018). Unconscious bias: training. An assessment of the evidence for effectiveness. Equality and human rights commission research report, 113.

Aveyard, H. (2023). Doing a Literature Review in Health and Social Care: A Practical Guide 5e.

Awad G.H, Patall E A, Rackley K R, Reilly E D (2016) Recommendations for culturally sensitive research methods. Journal of Educational and Psychological Consultation, 26(3), 283-303.

Awuchi, C. G. (2023). Medicinal Plants and Herbal Medicines in Africa. Important Medicinal and Aromatic Plants–Africa.

Azugbene, E. A. (2023). Maternal health experiences and health care utilization of African immigrant women: A review of the literature. Maternal and Child Health Journal, 27(8), 1324-1334.

Azugbene, E. A., Cornelius, L. J., & Johnson-Agbakwu, C. E. (2023). African Immigrant Women's Maternal Health Experiences in Clarkston, Georgia: A Qualitative Study. Women's Health Reports, 4(1), 603-616.

Azungah, T. (2018). Qualitative research: deductive and inductive approaches to data analysis. Qualitative research journal, 18(4), 383-400

Babatunde-Sowole, O., Power, T., Jackson, D., Davidson, P. M., & DiGiacomo, M. (2016). Resilience of African migrants: An integrative review. Health care for women international, 37(9), 946-963.

Bailey, J. (2008). First steps in qualitative data analysis: transcribing, Family Practice, 25(2),1:127–131, https://doi.org/10.1093/fampra/cmn003

Bains, S., Sundby, J., Lindskog, B. V., Vangen, S., & Sørbye, I. K. (2021). Newly arrived migrant women’s experience of maternity health information: a face-to-face questionnaire

study in Norway. International journal of environmental research and public health, 18(14), 7523.

Baker, S., & Edwards, R. (2017). How many qualitative interviews is enough? Expert voices and early career reflections on sampling and cases in qualitative research. National centre for research methods review paper.

Balaam, M., Akerjordet, K., Lyberg, A., Kaiser, B., Schoening, E., Fredriksen, A., . . . Severinsson, E. (2013). A qualitative review of migrant women's perceptions of their needs and experiences related to pregnancy and childbirth. Journal of Advanced Nursing (John Wiley & Sons, Inc.), 69(9), 1919-1930.

Balcetis, E. and Dunning, D. (2006), “See what you want to see: motivational influences on visual perception”, Journal of Personality and Social Psychology, Vol. 91, pp. 612-625.

Banister C E M, Begoray D L, Nimmon L E, Mills E A J, Durepos G, Wiebe E (2014) Encyclopedia of Case Study Research Cultural Sensitivity and Case Study 269–71

Barreiros, I. B., & Moreira, J. K. (2019). ‘To decolonize is to perform’: The Theory-in-Praxis of Grada Kilomba. In Challenging Memories and Rebuilding Identities (pp. 56-81). Routledge.

Bartoli, A., Chopping, T., Douglas, V., & Tedam, P. (2015). Embedding equality and diversity in the curriculum: a social work practitioner's guide. The Higher Education Academy-Scotland, 1-14.

Bassel, L., & Khan, K. (2021). Migrant women becoming British citizens: care and coloniality. Citizenship Studies, 25(4), 583-601.

Batinelli, L., McCourt, C., Bonciani, M., & Rocca-Ihenacho, L. (2023). Implementing midwifery units in a European country: Situational analysis of an Italian case study. Midwifery, 116, 103534.

Baumann, N. (2016). How to use the medical subject headings (MeSH). International journal of clinical practice, 70(2), 171-174.

Baxter, P. & Jack, S. (2008). Qualitative case study methodology: Study design and implementation for novice researchers. The Qualitative Report, 13(4), 544-559.

Beach, D. & Arrazola, B, V. (2019). Ethical review boards. Constitutions, functions, tensions, and blind spots. In: Busher H, Fox A (eds) Implementing Ethics in Educational Ethnography: Regulation and Practice. Milton: Routledge, 32–47.

Behboudi-Gandevani, S., Bidhendi-Yarandi, R., Panahi, M. H., Mardani, A., Paal, P., Prinds, C., & Vaismoradi, M. (2022). Adverse pregnancy outcomes and international immigration status: a systematic review and meta-analysis. Annals of Global Health, 88(1).

Bell, J., & Waters, S. (2018). Doing Your Research Project: A guide for first-time researchers. McGraw-hill education (UK).

Bellamy, K., Ostini, R., Martini, N., & Kairuz, T. (2016). Seeking to understand: Using generic qualitative research to explore access to medicines and pharmacy services among resettled refugees. International journal of clinical pharmacy, 38, 671-675.

Benza, S., & Liamputtong, P. (2014). Pregnancy, childbirth, and motherhood: a meta-synthesis of the lived experiences of immigrant women. Midwifery, 30(6), 575-584.

Berger, R. (2015). Now I see it, now I don't: Researcher's position and reflexivity in qualitative research. Qualitative research, 15(2), 219-234.

Berndt, A. e. (2020). Sampling methods. Journal of Human lactation, 36(2), 224-226.

Berry, J. W. (2006) Contexts of acculturation. In D. L. Sam & J. W. Berry (Eds.), The Cambridge handbook of acculturation psychology (p. 27–42). Cambridge University Press

Berry, J.W. & Sabatier, C., (2010). Acculturation, discrimination, and adaptation among second generation immigrant youth in Montreal and Paris. International journal of intercultural relations, 34(3), pp.191-207.

Beskow, L. M. (2016). Lessons from HeLa cells: the ethics and policy of biospecimens. Annual review of genomics and human genetics, 17(1), 395-417.

Birks, M., Hoare, K., & Mills, J. (2019). Grounded theory: the FAQs. International Journal of Qualitative Methods, 18, 1609406919882535.

Birks, M., & Mills, J. (2022). Grounded theory: A practical guide. Sage.

Birthrights. (2022). Systemic racism, not broken bodies, https://birthrights.org.uk/campaigns-research/racial-injustice/

Blaikie, N., & Priest, J. (2019). Designing social research: The logic of anticipation. John Wiley & Sons.

Blair, A., Tan, A., Homer, C. S., & Vogel, J. P. (2024). How do postnatal care guidelines in Australia compare to international standards? A scoping review and comparative analysis. BMC Pregnancy and Childbirth, 24(1), 121.

Blench, R. (2019). An Atlas of Nigerian Languages (4th ed.). Cambridge: Kay Williamson Educational Foundation.

Bollini, P., Pampallona, S., Wanner, P., & Kupelnick, B. (2009). Pregnancy outcome of migrant women and integration policy: a systematic review of the international literature. Social science & medicine, 68(3), 452-461.

Bowen, G. A. (2008). Naturalistic inquiry and the saturation concept: a research note. Qualitative research, 8(1), 137-152

Bowser, D., & Hill, K. (2010). Exploring evidence for disrespect and abuse in facility-based childbirth: report of a landscape analysis. USAID-Traction project.

Boynton, P. M. (2004). Administering, analysing, and reporting your questionnaire. Bmj, 328(7452), 1372-1375.

Brader, C (2024) Performance of maternity units in England. https://lordslibrary.parliament.uk/performance-of-maternity-services-in-england/

Bradford, B. F., Wilson, A. N., Portela, A., McConville, F., Fernandez Turienzo, C., & Homer, C. S. (2022). Midwifery continuity of care: A scoping review of where, how, by whom and for whom?. PLOS Global Public Health, 2(10), e0000935.

Bradshaw, C., Atkinson, S., & Doody, O. (2017). Employing a qualitative description approach in health care research. Global qualitative nursing research, 4, 2333393617742282.

Bramer, W. M., De Jonge, G. B., Rethlefsen, M. L., Mast, F., & Kleijnen, J. (2018). A systematic approach to searching: an efficient and complete method to develop literature searches. Journal of the Medical Library Association: JMLA, 106(4), 531.

Braun, V., Clarke, V., & Hayfield, N. (2022). ‘A starting point for your journey, not a map’: Nikki Hayfield in conversation with Virginia Braun and Victoria Clarke about thematic analysis. Qualitative research in psychology, 19(2), 424-445.

Breakwell, G. M. (2020). Mistrust, uncertainty and health risks. Contemporary Social Science, 15(5), 504-516.

Brooks, L. A., Manias, E., & Bloomer, M. J. (2019). Culturally sensitive communication in healthcare: A concept analysis. Collegian, 26(3), 383-391.

Brownstein, M. and Saul, J. (Eds) (2016), Implicit Bias and Philosophy, Volume 1: Metaphysics and Epistemology, Oxford University Press, Oxford.

Briscoe, L. (2013). Becoming culturally sensitive: A painful process?. Midwifery, 29(6), 559-565.

Brumpton, K., Ward, R., Evans, R., Neill, H., Woodall, H., McArthur, L., & Sen Gupta, T. (2023). Assessing cultural safety in general practice consultations for Indigenous patients: protocol for a mixed methods sequential embedded design study. BMC Medical Education, 23(1), 306.

Bryman, A. (2016). Social research methods. Oxford university press.

Bullock, A. (2016). Conduct one-to-one qualitative interviews for research. Education for Primary Care, 27(4), 330-332.

Bulman, K. H., & McCourt, C. (2002). Somali refugee women's experiences of maternity care in west London: a case study. Critical Public Health, 12(4), 365-380.

Bunniss, S., & Kelly, D. R. (2010). Research paradigms in medical education research. Medical education 44(4), 358–366.

Burchett, H. E., Mayhew, S. H., Lavis, J. N., & Dobrow, M. J. (2013). When can research from one setting be useful in another? Understanding perceptions of the applicability and transferability of research. Health promotion international, 28(3), 418-430.

Burden, S., Henshall, C., & Oshikanlu, R. (2021). Harnessing the nursing contribution to COVID-19 mass vaccination programmes: Addressing hesitancy and promoting confidence. Journal of Advanced Nursing, 77(8), e16-e20.

Burnette C E, Sanders S, Butcher H K, Rand J T (2014) A toolkit for ethical and culturally sensitive research: An application with Indigenous communities. Ethics and social welfare, 8(4), 364-382

Byrne, J. A. (2016). Improving the peer review of narrative literature reviews. Research integrity and peer review, 1, 1-4.

Cabiles, B. S. (2024). Internalised deficit perspectives: positionality in culturally responsive pedagogical frameworks. Pedagogy, Culture & Society, 1-18.

Caelli K, Ray L, Mill J. (2003). 'Clear as Mud': toward greater clarity in generic qualitative research. Int J Qual Methods. 2(2):1–13.

Campbell C (2021). Medical violence, obstetric racism, and the limits of informed consent for Black women. J. Race & L, 47.

Campinha-Bacote, J. (2002). The process of cultural competence in the delivery of healthcare services: A model of care. Journal of transcultural nursing, 13(3), 181-184.

Campinha-Bacote, J. (2008). Cultural desire: 'caught' or 'taught'?. Contemporary nurse, 28(1-2), 141-148.

Campinha-Bacote, J. (2011). Delivering patient-centered care in the midst of a cultural conflict: the role of cultural competence. Online journal of issues in nursing, 16(2).

Capper, T. S., Williamson, M., & Chee, R. (2023). How is cultural safety understood and translated into midwifery practice? A scoping review and thematic analysis. Nurse Education in Practice, 66, 103507.

Carnwell, R., & Daly, W. (2001). Strategies for the construction of a critical review of the literature. Nurse education in practice, 1(2), 57-63.

Carolan, M., & Cassar, L. (2010). Antenatal care perceptions of pregnant African women attending maternity services in Melbourne, Australia. Midwifery, 26(2), 189-201.

Carroll, C., Booth, A., Leaviss, J., & Rick, J. (2013). “Best fit” framework synthesis: refining the method. BMC medical research methodology, 13, 1-16.

Carter, L., & Rossi, A. (2021). Embodying strength: The origin, representations, and socialization of the strong Black woman ideal and its effect on Black women's mental health. In *WE Matter!* (pp. 43-54). Routledge.

Carter, S. M., Shih, P., Williams, J., Degeling, C., & Mooney-Somers, J. (2021). Conducting qualitative research online: Challenges and solutions. The Patient-Patient-Centered Outcomes Research, 14(6), 711-718.

Casey, S., Moss, S., & Wicks, J. (2022). Therapists’ experiences of play therapy with Muslim families in Western Countries: The importance of cultural respect. International Journal of Play Therapy, 31(1), 56.

CASP. (2024). Critical appraisal checklists. https://casp-uk.net/casp-tools-checklists/

Cbe, J. S. (2017). The contribution of continuity of midwifery care to high quality maternity care. The Royal Collage of Midwives.

CEMACH. (2004). *Saving Mothers' Lives: reviewing maternal deaths to make motherhood safer*: 2003-2005. CEMACH.

Cénat, J. M., Moshirian Farahi, S. M. M., Bakombo, S. M., Dalexis, R. D., Pongou, R., Caulley, L., ... & Venkatesh, V. (2023). Vaccine mistrust among Black individuals in Canada: The major role of health literacy, conspiracy theories, and racial discrimination in the healthcare system. Journal of Medical Virology, 95(4), e28738.

Chafe, R. (2017) "The value of qualitative description in health services and policy research. Healthcare policy, 12(3),12.

Charmaz, K. (2006). Constructing grounded theory: A practical guide through qualitative analysis. sage.

Charmaz, K., & Thornberg, R. (2021). The pursuit of quality in grounded theory. Qualitative research in psychology, 18(3), 305-327.

Charsley, K., & Wray, H. (2015). Introduction: The invisible (migrant) man. Men and Masculinities, 18(4), 403-423.

Chauhan, A., Walton, M., Manias, E., Walpola, R. L., Seale, H., Latanik, M., ... & Harrison, R. (2020). The safety of health care for ethnic minority patients: a systematic review. International journal for equity in health, 19, 1-25.

Chhabra, G. (2020). Insider, outsider or an in-betweener? Epistemological reflections of a legally blind researcher on conducting cross-national disability research.

Choak, C. (2012). Asking questions: Interviews and evaluations. In S. Bradford, & F. Cullen, Research, and research methods for youth practitioners (pp. 90–112). London: Routledge.

Chikako, N., & Joseph, V. A. (2017). Spiritual meaning of placenta disposal. Journal of Comprehensive Nursing Research and Care, 2(1), 106.

Chilisa, B. (2019). Indigenous research methodologies. Sage publications.

Chilisa, B., Kawulich, B., Wagner, C., Kawulich, B. B., & Garner, M. (2012). Doing social research: A global context. Europe, Middle East & Africa: McGraw-Hill.

Chitongo, S., Pezaro, S., Fyle, J., Suthers, F., & Allan, H. (2022). Midwives' insights in relation to the common barriers in providing effective perinatal care to women from ethnic minority groups with 'high risk'pregnancies: A qualitative study. Women and Birth, 35(2), 152-159.

Chowdhury, A. M. M., Helman, C., & Greenhalgh, T. (2023). Food beliefs and practices among British Bangladeshis with diabetes: implications for health education. In Medical Anthropology (pp. 5-22). Routledge

Choy, B., Arunachalam, K., Gupta, S., Taylor, M., & Lee, A. (2021). Systematic review: Acculturation strategies and their impact on the mental health of migrant populations. Public Health in Practice, 100069.

Chinouya, M. J., & Madziva, C. (2019). Late booking amongst African women in a London borough, England: implications for health promotion. Health promotion international, 34(1), 123-132.

Christ, T. W. (2014). Scientific-based research and randomized controlled trials, the “gold” standard? Alternative paradigms and mixed methodologies. Qualitative Inquiry, 20(1), 72-80.

Chua, P. (2017). Cultural racism. The Wiley-Blackwell encyclopaedia of social theory, 1-3.

Claeys, A., Berdai-Chaouni, S., Tricas-Sauras, S., & De Donder, L. (2021). Culturally sensitive care: Definitions, perceptions, and practices of health care professionals. Journal of transcultural nursing, 32(5), 484-492.

Clandinin, D. J. (2022). Engaging in narrative inquiry. Routledge.

Clarke, V., & Braun, V. (2013). Successful qualitative research: A practical guide for beginners. Successful qualitative research, 1-400.

Cleland, J. A. (2017). The qualitative orientation in medical education research. Korean Journal of Medical Education, Jun 29(2), 6-71.

CMACE. (2011). *Saving Mothers' Lives: reviewing maternal deaths to make motherhood safer: 2006–08. The Eighth Report on Confidential Enquiries into Maternal Deaths in the United Kingdom.* BJOG 2011;118(Suppl. 1):1–203.

Coast, E., Jones, E., Portela, A., & Lattof, S. R. (2014). Maternity care services and culture: a systematic global mapping of interventions. PloS one, 9(9), e108130.

Coleman, P. (2022). Validity and reliability within qualitative research for the caring sciences. International Journal of Caring Sciences, 14(3), 2041-2045.

Colorafi, K. J., & Evans, B. (2016). Qualitative descriptive methods in health science research. HERD: Health Environments Research & Design Journal, 9(4), 16-25.

Connelly, L. M. (2016). Trustworthiness in qualitative research. Medsurg nursing, 25(6), 435.

Corbin. J., & Strauss. A. (2007). Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory. 3rd ed. California: Sage,

Cornwall, J., Mayland, E. C., van der Meer, J., Spronken-Smith, R. A., Tustin, C., & Blyth, P. (2019). Stressors in early-stage doctoral students. Studies in Continuing Education, 41(3), 363-380.

Coxon, K., Turienzo, C. F., Kweekel, L., Goodarzi, B., Brigante, L., Simon, A., & Lanau, M. M. (2020). The impact of the coronavirus (COVID-19) pandemic on maternity care in Europe. Midwifery, 88, 102779.

Crawford, T., Candlin, S., & Roger, P. (2017). New perspectives on understanding cultural diversity in nurse–patient communication. Collegian, 24(1), 63-6, J. W. (2007). Qualitative inquiry and research design: Choosing among five traditions (2nd Ed). Thousand Oaks, CA: Sage

Creswell, J. W. (2014). A concise introduction to mixed methods research. SAGE publications.

Cronin, A. (2008). Focus groups. Researching social life, 3, 226-244.

Cross, T. L. (1989). Towards a culturally competent system of care: A monograph on effective services for minority children who are severely emotionally disturbed.

Cross-Sudworth, F. (2007). Racism and discrimination in maternity services. British Journal of Midwifery, 15(6), 327-331.

Crotty, M. J. (1998). The foundations of social research: Meaning and perspective in the research process. The foundations of social research, 1-256.

Cull, J., Brooks, E., Anwar, N., Cunningham, J., Forman, J., & Hall, D. (2022). Why are some voices not heard? Exploring how maternity care can be improved for women with limited English. MIDIRS Midwifery Digest, 32(2), 142-146.

Cunningham, A., & Andrews, B. (2017). Introduction: Western medicine as contested knowledge. In Western medicine as contested knowledge (pp. 1-23). Manchester University Press.

Cupples, J., & Grosfoguel, R. (Eds.). (2019). Unsettling eurocentrism in the Westernized University. Abingdon: Routledge.

Cupsa, I. (2018). “Culture shock and identity.” Transactional Analysis Journal, 48(2), 181-191.

Curtis, E., Jones, R., Tipene-Leach, D., Walker, C., Loring, B., Paine, S. J., & Reid, P. (2019). Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition. International journal for equity in health, 18, 1-17.

Cypress, B. S. (2015). Qualitative research: the “what,”“why,”“who,” and “how”!. Dimensions of Critical Care Nursing, 34(6), 356-361.

Cyr, J. (2016). The pitfalls and promise of focus groups as a data collection method. Sociological methods & research, 45(2), 231-259.

Dai, X. (2020). An Analysis of The Promotion Effect of the Traditional Song and Dance Culture of Yi Nationality on the Rural Customs and Civilization. *Frontiers in Art Research*, *2*(7).

Damarell, R. A., Morgan, D. D., & Tieman, J. J. (2020). General practitioner strategies for managing patients with multimorbidity: a systematic review and thematic synthesis of qualitative research. BMC Family Practice, 21, 1-23.

Daniels, N., Gillen, P., Casson, K., & Wilson, I. (2019). STEER: Factors to consider when designing online focus groups using audiovisual technology in health research. International Journal of Qualitative Methods, 18, 1609406919885786.

Datta R (2018) Decolonizing both researcher and research and its effectiveness in Indigenous research. Research Ethics, 14(2), 1-24.

Davis, D. (2020). Presenting research reflexivity in your PhD thesis. Nurse researcher, 28(3).

Davis, D. L., & Homer, C. S. (2016). Birthplace as the midwife's workplace: How does place of birth impact on midwives?. Women and Birth, 29(5), 407-415.

Dawson, J., Laccos-Barrett, K., Hammond, C., & Rumbold, A. (2022). Reflexive practice as an approach to improve healthcare delivery for Indigenous peoples: A systematic critical synthesis and exploration of the cultural safety education literature. International journal of environmental research and public health, 19(11), 6691.

De, D., & Richardson, J. (2008). Cultural safety: an introduction. Nursing Children and Young People, 20(2).

de Diego-Cordero, R., Rivilla-Garcia, E., Diaz-Jimenez, D., Lucchetti, G., & Badanta, B. (2021). The role of cultural beliefs on eating patterns and food practices among pregnant women: a systematic review. Nutrition reviews, 79(9), 945-963.

De Freitas, C., Massag, J., Amorim, M., & Fraga, S. (2020). Involvement in maternal care by migrants and ethnic minorities: A narrative review. Public Health Reviews, 41, 5.

Degni, F., Suominen, S. B., El Ansari, W., Vehviläinen-Julkunen, K., & Essen, B. (2014). Reproductive and maternity health care services in Finland: Perceptions and experiences of Somali-born immigrant women. Ethnicity & Health, 19(3), 348-366.

Degni, F., Suominen, S., Essén, B., El Ansari, W., & Vehviläinen-Julkunen, K. (2012). Communication and cultural issues in providing reproductive health care to immigrant women: health care providers' experiences in meeting Somali women living in Finland. Journal of immigrant and minority health, 14, 330-343.

DeJonckheere, M., & Vaughn, L. M. (2019). Semistructured interviewing in primary care research: a balance of relationship and rigour. Family medicine and community health, 7(2).

de la Croix, A., Barrett, A., & Stenfors, T. (2018). How to… do research interviews in different ways. The clínical teacher, 15(6), 451-456.

Del Pilar, J. A., & Udasco, J. O. (2004). Deculturation: its lack of validity. Cultural diversity and ethnic minority psychology, 10(2), 169.

Deliz, J. R., Fears, F. F., Jones, K. E., Tobat, J., Char, D., & Ross, W. R. (2020). Cultural competency interventions during medical school: a scoping review and narrative synthesis. Journal of general internal medicine, 35(2), 568-577.

Dempsey, L., Dowling, M., Larkin, P., & Murphy, K. (2016). Sensitive interviewing in qualitative research. Research in nursing & health, 39(6), 480-490.

Denzin, N. k., & Lincoln, Y. s. (2018). Introduction. In N.K. Denzin& Y.S. Lincoln (Ed's.) The Sage handbook of qualitative research (5th ed., pp. 1-26) Los Angeles, CA. : Sage.

de Villiers, C., Farooq, M. B., & Molinari, M. (2021). Qualitative research interviews using online video technology–challenges and opportunities. Meditari Accountancy Research.

Devonport, T. J., Ward, G., Morrissey, H., Burt, C., Harris, J., Burt, S., ... & Nicholls, W. (2023). A systematic review of inequalities in the mental health experiences of Black African, Black Caribbean, and Black-mixed UK populations: Implications for action. Journal of racial and ethnic health disparities, 10(4), 1669-1681.

Dike, P. (2013). Birth practices of Nigerian women in the UK. British Journal of Midwifery, 21(1), 41-52.

Dike, P. (2019). Does culture influence birth experiences of first-generation Nigerian women in London. International Journal of Nursing and Midwifery, 11(8), 87-102.

Dixon-Woods, M., Foy, C., Hayden, C., Salman, R. A. S., Tebbutt, S., & Schroter, S. (2016). Can an ethics officer role reduce delays in research ethics approval? A mixed-method evaluation of an improvement project. BMJ open, 6(8), e011973.

Dobbin, F., & Kalev, A. (2018). Why doesn't diversity training work? The challenge for industry and academia. Anthropology Now, 10(2), 48-55.

DoH. (2000) The NHS plan- A plan for investment, A plan for reform, London, HMSO.

DoH (2004) National service framework: children, young people, and maternity services. https://www.gov.uk/government/publications/national-service-framework-children-young-people-and-maternity-services.

DoH (2007). Maternity matters: choice, access, and continuity of care in a safe service. Department of Health.

DoH (2009) Report on the self-reported experience of patients from Black and minority ethnic groups: https://assets.publishing.service.gov.uk/media/5a7c475740f0b62dffde107b/BME-report-June-09-FINAL3.pdf

DoH. (2010).Midwifery 2020. Delivering expectations, https://assets.publishing.service.gov.uk/media/5a7c95cae5274a7b7e3216cd/dh_119470.pdfDOH

Dodgson, J. E. (2019). Reflexivity in qualitative research. Journal of Human Lactation, 35(2), 220-222.

Domboka, T. (2017). The Migration History of Black Africans to Britain. In Diasporas and Transnational Entrepreneurship in Global Contexts (pp. 188-204). IGI Global.

Downe, S., Finlayson, K., Oladapo, O., Bonet, M., & Gülmezoglu, A. M. (2018). What matters to women during childbirth: a systematic qualitative review. PloS one, 13(4), e0194906.

Downe, S., Finlayson, K., Tunçalp, Ö., & Gülmezoglu, A. M. (2019). Provision and uptake of routine antenatal services: a qualitative evidence synthesis. Cochrane Database of Systematic Reviews, (6).

Doyle, S. (2013). Reflexivity and the capacity to think. Qualitative health research, 23(2), 248-255.

Doyle, L., McCabe, C., Keogh, B., Brady, A., & McCann, M. (2020). An overview of the qualitative descriptive design within nursing research. Journal of research in nursing, 25(5), 443-455

Drake, M., Wilson, L., Desai, R., & Atherton, B. (2022). The Experiences of Black, Asian and Minority Ethnic Women of Maternity Services in the UK. Journal of Medical and Health Studies, 3(4), 32-43.

Drame, I., Unonu, J., Turner, M., Taylor, M. D., Bush, A., Jarvis, M., & Cawthorne, T. A. (2021). The association between students' emotional intelligence, cultural competency, and cultural awareness. Currents in Pharmacy Teaching and Learning, 13(9), 1146-1152.

Draper ES, Gallimore ID, Kurinczuk JJ, Kenyon SL (Eds). (2023). on behalf of the MBRRACE-UK Collaboration. MBRRACE-UK Perinatal Confidential Enquiry, A comparison of the care of Black and White women who have experienced a stillbirth or neonatal death: State of the Nation Report. Leicester: The Infant Mortality and Morbidity Studies, Department of Population Health Sciences, University of Leicester.

Drawson, A. S., Toombs, E., & Mushquash, C. J. (2017). Indigenous Research Methods. International Indigenous Policy Journal, 8(2), 1-25.

Dworkin, S. L. (2012). Sample size policy for qualitative studies using in-depth interviews. Archives of sexual behavior, 41, 1319-1320.

Dwyer, S. C., & Buckle, J. L. (2009). The space between: On being an insider-outsider in qualitative research. International journal of qualitative methods, 8(1), 54-63.

Dyer, C. (2022). East Kent Hospitals:“This cannot go on,” says doctor who found that babies could have survived with standard care.

Edmonds WA, Kennedy TD. (2016) An Applied Guide to Research Designs: Quantitative, Qualitative, and Mixed Methods. Los Angeles, CA: Sage.

Eigenbrod, R., & Hulan, R. (Eds.). (2008). *Aboriginal oral traditions: Theory, practice, ethics*. Fernwood Publishing

Einola, K., & Alvesson, M. (2021). Behind the numbers: Questioning questionnaires. Journal of Management Inquiry, 30(1), 102-114.

Elam, G., & Chinouya, M. (2000). Feasibility Study for Health Surveys Among Black African Populations Living in the UK: Stage 2-Diversity Among Black African Communuities. London: Department of Health.

Elam, G., McMunn, A., Nazroo, J., Apwonyoke, M., Brookes, M., Chinouya, M., ... & Lutaaya, G. (2001). Feasibility study for health surveys among Black African people living in England. Final report-implications for the Health Survey for England. London: Department of Health.

Ellis, J. L., & Hart, D. L. (2023). Strengthening the Choice for a Generic Qualitative Research Design. The Qualitative Report, 28(6), 1759-1768.

Ellis, L. A., Falkland, E., Hibbert, P., Wiig, S., Ree, E., Schultz, T. J., ... & Braithwaite, J. (2023). Issues and complexities in safety culture assessment in healthcare. Frontiers in Public Health, 11, 1217542.

Erens, B., Primatesta, P., & Prior, G. (2001). Health survey for England 1999: the health of ethnic minority groups. London: The Stationery Office

Erlingsson, C., & Brysiewicz, P. (2017). A hands-on guide to doing content analysis. African journal of emergency medicine, 7(3), 93-99.

Erves, J. C., Mayo-Gamble, T. L., Malin-Fair, A., Boyer, A., Joosten, Y., Vaughn, Y. C., ... & Wilkins, C. H. (2017). Needs, priorities, and recommendations for engaging

underrepresented populations in clinical research: a community perspective. Journal of community health, 42, 472-480.

Esegbona-Adeigbe, S. (2011). Acquiring cultural competency in caring for Black African women. British Journal of Midwifery, 19(8), 489-496.

Esegbona-Adeigbe, S. (2018). Cultural qualities and antenatal care for Black African women: A literature review. British Journal of Midwifery, 26(8), 532-539.

Esegbona-Adeigbe, S. (2022). Transcultural Midwifery Practice-E-Book: Concepts, Care and Challenges. Elsevier Health Sciences.

Espinoza, R., Martínez, I., Levin, M., Rodriguez, A., Chan, T., Goldenberg, S., & Zúñiga, M. L. (2014). Cultural perceptions and negotiations surrounding sexual and reproductive health among migrant and non-migrant Indigenous Mexican women from Yucatán, Mexico. Journal of immigrant and minority health, 16, 356-364.

European Union Agency for Fundamental Rights. (2023). Being Black in the EU-Experiences of people of African descent. https://fra.europa.eu/en/publication/2018/being-black-eu

Evans, M., Hole, R., Berg, L. D., Hutchinson, P., & Sookraj, D. (2009). Common insights, differing methodologies: Toward a fusion of indigenous methodologies, participatory action research, and white studies in an urban Aboriginal research agenda. *Qualitative inquiry*, *15*(5), 893-910.

Evans, C., & Lewis, J. (2018). Analysing semi-structured interviews using thematic analysis: Exploring voluntary civic participation among adults (pp. 1-6). SAGE Publications Limited.

Fair, F., Raben, L., Watson, H., Vivilaki, V., van den Muijsenbergh, M., Soltani, H., & ORAMMA team. (2020). Migrant women's experiences of pregnancy, childbirth, and maternity care in European countries: A systematic review. PloS one, 15(2), e0228378.

Farrugia, B. (2019). WASP (write a scientific paper): Sampling in qualitative research. Early human development, 133, 69-71.

Ferrari, R. (2015). Writing narrative style literature reviews. Medical writing, 24(4), 230-235.

Finlay, L. (2011). Phenomenology for therapists: Researching the lived world. John Wiley and Sons.

Fischer, E., & Guzel, G. T. (2022). The case for qualitative research. Journal of Consumer Psychology.

Fivexmore. (2024). Campaigning for better maternal health outcomes. https://fivexmore.org/

Fleming T, Creedy D K, West R. 2019a. Evaluating awareness of Cultural Safety in the Australian midwifery workforce: A snapshot. Women and Birth, 32(6): 549-557.

Fleming T, Creedy D K, West R. 2019b. The influence of yarning circles: A cultural safety professional development program for midwives. Women and Birth, 33 (2), 175-185.

Fletcher-Brown J (2020) Reflexivity and the challenges of collecting sensitive data in India: a research note. Qualitative Research, 20(1), 108-118.

Floersch, J., Longhofer, J. L., Kranke, D., & Townsend, L. (2010). Integrating thematic, grounded theory and narrative analysis: A case study of adolescent psychotropic treatment. Qualitative Social Work, 9(3), 407-425.

Flynn, R., Albrecht, L., & Scott, S. D. (2018). Two approaches to focus group data collection for qualitative health research: maximizing resources and data quality. International Journal of Qualitative Methods, 17(1), 1609406917750781.

Ford, B. Q., Green, D. J., & Gross, J. J. (2022). White fragility: An emotion regulation perspective. American Psychologist, 77(4), 510.

Foronda, C. L. (2008). Cultural sensitivity: A concept analysis. Journal of Transcultural Nursing, 19(3), 207-212.

Fox, R. S., Merz, E. L., Solórzano, M. T., & Roesch, S. C. (2013). Further examining Berry's model: The applicability of latent profile analysis to acculturation. Measurement and Evaluation in Counseling and Development, 46(4), 270-288.

Fozdar, F. (2023). Belonging in the land down under: Black Africans in Australia. International Migration, 61(1), 23-38.

Frechette, J., Bitzas, V., Aubry, M., Kilpatrick, K., & Lavoie-Tremblay, M. (2020). Capturing lived experience: Methodological considerations for interpretive phenomenological inquiry. International Journal of Qualitative Methods, 19, 1609406920907254.

Frey, W. R. (2020). White fragility: Why it's so hard for white people to talk about racism Robin DiAngelo.

Gagnon, A. J., Zimbeck, M., Zeitlin, J., & Roam Collaboration. (2009). Migration to western industrialised countries and perinatal health: a systematic review. Social science & medicine, 69(6), 934-946.

Gammie, E., Hamilton, S., & Gilchrist, V. (2017). Focus group discussions. The Routledge Companion to Qualitative Accounting Research Methods, Taylor & Francis, New York, NY, 372-386.

Garcia, R. (2022). Social determinants of health. A Population Health Approach to Health Disparities for Nurses: Care of Vulnerable Populations.

Garcia, R., Ali, N., Papadopoulos, C., & Randhawa, G. (2015). Specific antenatal interventions for Black, Asian, and Minority Ethnic (BAME) pregnant women at high risk of poor birth outcomes in the United Kingdom: a scoping review. BMC pregnancy and childbirth, 15, 1-13.

Germain, S., & Yong, A. (2020). COVID-19 highlighting inequalities in access to healthcare in England: a case study of ethnic minority and migrant women. Feminist legal studies, 28(3), 301-310

Gerrish, K., & Lacey, A. (2010). The research process in nursing. John Wiley & Sons.

Glaw, X., Inder, K., Kable, A., & Hazelton, M. (2017). Visual methodologies in qualitative research: Autophotography and photo elicitation applied to mental health research. *International journal of qualitative methods*, *16*(1), 1609406917748215

Gill, P., & Baillie, J. (2018). Interviews and focus groups in qualitative research: an update for the digital age. British dental journal, 225(7), 668-672.

Gill, P. Stewart, K. Treasure, E. & Chadwick, B. (2008). Methods of data collection in qualitative research: interviews and focus groups, British Dental Journal, 294(6), 291-295.

Gill, S. L. (2020). Qualitative sampling methods. Journal of Human Lactation, 36(4), 579-581.

Goberna Tricas, J., Vixas Llebot, H., PalacioTauste, A., Galt García, M., Pault Cabezas, À, & Gómez Moreno, C. (2005). Prenatal care in African immigrants. the perception of primary care midwives. Enfermería Clínica, 15(2), 88-94.

Goertzen, M.J. (2017). Applying Quantitative Methods to E-Book Collections. Library technology reports, 53, 1.

Gopal, D. P., Chetty, U., O'Donnell, P., Gajria, C., & Blackadder-Weinstein, J. (2021). Implicit bias in healthcare: clinical practice, research and decision making. Future healthcare journal, 8(1), 40.

Gotlieb, R., Praska, C., Hendrickson, M. A., Marmet, J., Charpentier, V., Hause, E., ... & Pitt, M. B. (2022). Accuracy in patient understanding of common medical phrases. JAMA Network Open, 5(11), e2242972-e2242972.

Goyes, D. R., & Sandberg, S. (2024). Trust, nuance, and care: Advantages and challenges of repeat qualitative interviews. Qualitative Research, 14687941241246159.

Graham, R., & Clarke, V. (2021). Staying strong: Exploring experiences of managing emotional distress for African Caribbean women living in the UK. Feminism & Psychology, 31(1), 140-159.

Graneheim, U. H., & Lundman, B. (2004). Qualitative content analysis in nursing research: concepts, procedures, and measures to achieve trustworthiness. Nurse education today, 24(2), 105-112.

Graneheim, U. H., Lindgren, B. M., & Lundman, B. (2017). Methodological challenges in qualitative content analysis: A discussion paper. Nurse education today, 56, 29-34.

Grant, M. J., & Booth, A. (2009). A typology of reviews: an analysis of 14 review types and associated methodologies. Health information & libraries journal, 26(2), 91-108.

Gray, R., Headley, J., Oakley, L., Kurinczuk, J. J., Brocklehurst, P., & Hollowell, J. (2009). Towards an understanding of variations in infant mortality rates between different ethnic groups in England and Wales. National Primate Epidemiology Unit, University of Oxford, and Department of Public Health (November 2009), 1-9.

Greenwood, N., Ellmers, T., & Holley, J. (2014). The influence of ethnic group composition on focus group discussions. BMC medical research methodology, 14, 1-13.

Grossoehme, D. H. (2014). Overview of qualitative research. Journal of health care chaplaincy, 20(3), 109-122.

Guba, E. G. (1990). The paradigm dialog. In Alternative paradigms conference, mar, 1989, indiana u, school of education, san francisco, ca, us. Sage Publications, Inc.

Guba, E. G., & Lincoln, Y. S. (1989). Fourth generation evaluation. Sage.

Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. Field methods, 18(1), 59-82.

Guest, G., Namey, E., & McKenna, K. (2017). How many focus groups are enough? Building an evidence base for nonprobability sample sizes. Field methods, 29(1), 3-22.

Hadi, M. A., & José Closs, S. (2016). Ensuring rigour and trustworthiness of qualitative research in clinical pharmacy. International journal of clinical pharmacy, 38, 641-646.

Hahn, A., & Gawronski, B. (2019). Facing one's implicit biases: From awareness to acknowledgment. Journal of personality and social psychology, 116(5), 769.

Hancock, M. E., Amankwaa, L., Revell, M. A., & Mueller, D. (2016). Focus Group Data Saturation: A New Approach to Data Analysis. The Qualitative Report, 21(11), 2124-2130. Retrieved from http://nsuworks.nova.edu/tqr/vol21/iss11/13

Hall E T. 1984. The Dance of Life: The Other Dimension of Time. Garden City: New York NY.

Hall, G. C. N., Yip, T., & Zárate, M. A. (2016). On becoming multicultural in a monocultural research world: A conceptual approach to studying ethnocultural diversity. American Psychologist, 71(1), 40.

Hall, W. J. (2024). Recognizing Stereotypes and Their Impact on Health: A Transformative Learning Activity for Undergraduate Health Science Students. Pedagogy in Health Promotion, 10(2), 98-104.

Hammersley, M., & Atkinson, P. (2019). Ethnography: Principles in practice. Routledge.

Hansbrough, T. K., Lord, R. G., & Schyns, B. (2015). Reconsidering the accuracy of follower leadership ratings. The Leadership Quarterly, 26(2), 220–237.

Harari, M. B., Parola, H. R., Hartwell, C. J., & Riegelman, A. (2020). Literature searches in systematic reviews and meta-analyses: A review, evaluation, and recommendations. Journal of Vocational Behavior, 118, 103377.

Harrison, R., Walton, M., Chauhan, A., Manias, E., Chitkara, U., Latanik, M., & Leone, D. (2019). What is the role of cultural competence in ethnic minority consumer engagement? An analysis in community healthcare. International Journal for Equity in Health, 18, 1-9.

Hassan, S. M. (2017). A qualitative study exploring British Muslim women's experiences of motherhood while engaging with NHS maternity services. Liverpool John Moores University (United Kingdom).

Hatch, S., Fitzgibbon, J., Tonks, A. J., & Forty, L. (2024). Diversity in patient and public involvement in healthcare research and education—realising the potential. Health Expectations, 27(1), e13896.

Hause, E., Praska, C., Pitt, M. B., Hendrickson, M. A., Charpentier, V., Allen, K. A., ... & Marmet, J. (2022). What's in a name? Laypeople's understanding of medical roles and titles. Journal of hospital medicine, 17(12), 956-960.

Helman C G. 2007. Culture, Health, and Illness, (5th ed.), Hodder Arnold: Oxford.

Hemmler, V. L., Kenney, A. W., Langley, S. D., Callahan, C. M., Gubbins, E. J., & Holder, S. (2022). Beyond a coefficient: An interactive process for achieving inter-rater consistency in qualitative coding. Qualitative Research, 22(2), 194-219.

Henderson, J., Gao, H., & Redshaw, M. (2013). Experiencing maternity care: the care received and perceptions of women from different ethnic groups. BMC pregnancy and childbirth, 13, 1-14.

Henderson, C., Scott, T., Schinder, B., Hager, E., Friedman, F. S., Miller, E., & Ragavan, M. I. (2024). Shifting the paradigm from participant mistrust to researcher & institutional trustworthiness: a qualitative study of researchers' perspectives on building trustworthiness with Black communities. Community Health Equity Research & Policy, 44(2), 127-136.

Hennink, M., & Kaiser, B. N. (2022). Sample sizes for saturation in qualitative research: A systematic review of empirical tests. Social science & medicine, 292, 114523.

Hennink, M. M., Kaiser, B. N., & Weber, M. B. (2019). What influences saturation? Estimating sample sizes in focus group research. Qualitative health research, 29(10), 1483-1496.

Hiam, L., Gionakis, N., Holmes, S. M., & McKee, M. (2019). Overcoming the barriers migrants face in accessing health care. Public Health, 172, 89-92.

Hiebl, M. R. (2023). Sample selection in systematic literature reviews of management research. Organizational research methods, 26(2), 229-261.

Higginbottom, G. M. A., Evans, C., Morgan, M., Bharj, K. K., Eldridge, J., & Hussain, B. (2019). Experience of and access to maternity care in the UK by immigrant women: A narrative synthesis systematic review. BMJ Open, 9(12).

Higginbottom, G. M., Richter, M. S., Mogale, R. S., Ortiz, L., Young, S., & Mollel, O. (2011). Identification of nursing assessment models/tools validated in clinical practice for use with diverse ethno-cultural groups: an integrative review of the literature. BMC nursing, 10, 16. https://doi.org/10.1186/1472-6955-10-16

Hill, N., Hunt, E., & Hyrkäs, K. (2012). Somali immigrant women's health care experiences and beliefs regarding pregnancy and birth in the United States. Journal of Transcultural Nursing : Official Journal of the Transcultural Nursing Society, 23(1), 72-81.

Hill, T., Mannheimer, A., & Roos, J. M. (2021). Measuring white fragility. Social Science Quarterly, 102(4), 1812-1829.

Hoagwood, K., Jensen, P. S., & Fisher, C. B. (2014). Ethical issues in mental health research with children and adolescents. Routledge.

Hoare, J. P., Thomas, S., & Jolly, A. (2024). Early action in the asylum support sector: a scoping review. Journal of Poverty and Social Justice, 1-21.

Hogan, R., Rossiter, C., & Catling, C. (2018). Cultural empathy in midwifery students: Assessment of an education program. Nurse education today, 70, 103-108.

Holland, K. (2017). Cultural diversity and professional practice. In Cultural Awareness in Nursing and Health Care (pp. 237-246). Routledge.

Hoon Lim, J. (2011). Qualitative methods in adult development and learning: Theoretical traditions, current practices, and emerging horizons.

Home Office. (2021. Women’s health: migrant guide, https://www.gov.uk/guidance/womens-health-migrant-health-guide

Hsieh, H. F., & Shannon, S. E. (2005). Three approaches to qualitative content analysis. Qualitative health research, 15(9), 1277-1288.

Hultsjö, S., Bachrach-Lindström, M., Safipour, J., & Hadziabdic, E. (2019). “Cultural awareness requires more than theoretical education”-Nursing students’ experiences. Nurse Education in Practice, 39, 73-79.

Husserl, E. (1983). Ideas pertaining to a pure phenomenology and to a phenomenological philosophy: First book: General introduction to a pure phenomenology (Vol. 2). Springer Science & Business Media.

Huston, S. A., & Hobson, E. H. (2008). Using focus groups to inform pharmacy research. Research in social and administrative pharmacy, 4(3), 186-205.

Igbineweka, N. E., Tshuma, N., & Roy, N. (2021). Medical science must address health disparities amongst different ethnic groups. Nature Human Behaviour, 1-3.

Ikafa, I., Hack-Polay, D., Walker, J., & Mahmoud, A. B. (2022). African migrants and stress coping strategies in Australia: Implications for social work. International Social Work, 65(6), 1166-1183.

Imran, A., Mpofu, S., & Weldon, S. M. (2021). Clinical research nurses, perspectives on recruitment challenges and lessons learnt from a large multi-site observational study. Journal of Research in Nursing, 17449871211043746.

Ingram, R. R. (2012). Using Campinha-Bacote's process of cultural competence model to examine the relationship between health literacy and cultural competence. Journal of advanced nursing, 68(3), 695-704.

Isaacs, A., Burns, N., Macdonald, S., & O'Donnell, C. A. (2022). 'I don't think there's anything I can do which can keep me healthy': how the UK immigration and asylum system shapes the health & wellbeing of refugees and asylum seekers in Scotland. Critical public health, 32(3), 422-432.

Isaacs, A. N., Raymond, A., Jacob, E., Jones, J., McGrail, M., & Drysdale, M. (2016). Cultural desire need not improve with cultural knowledge: A cross-sectional study of student nurses. Nurse Education in Practice, 19, 91-96.

Ishola, F., Owolabi, O., & Filippi, V. (2017). Disrespect and abuse of women during childbirth in Nigeria: a systematic review. PloS one, 12(3), e0174084.

Islam, M. A., & Aldaihani, F. M. F. (2022). Justification for Adopting Qualitative Research Method, Research Approaches, Sampling Strategy, Sample Size, Interview Method, Saturation, and Data Analysis. Journal of International Business and Management, 5(1), 01-11.

Jackman, P. C., Sanderson, R., Haughey, T. J., Brett, C. E., White, N., Zile, A., ... & Byrom, N. C. (2021). The impact of the first COVID-19 lockdown in the UK for doctoral and early career researchers. Higher Education, 1-18.

James, P. B., Renzaho, A. M., Mwanri, L., Miller, I., Wardle, J., Gatwiri, K., & Lauche, R. (2022). The prevalence of anxiety, depression, and post-traumatic stress disorder among African migrants: A systematic review and meta-analysis. Psychiatry research, 317, 114899.

Jamie, K. (2013). Navigating the UK NHS ethics and governance approval process: the case of junior researchers. Nova Science Publishers.

Jensen, S. Q. (2011). Othering, identity formation and agency. Qualitative studies, 2(2), 63-78.

Jerolmack, C., & Khan, S. (2014). Talk is cheap: Ethnography and the attitudinal fallacy. Sociological methods & research, 43(2), 178-209.

Johnson, J. L., Adkins, D., & Chauvin, S. (2020). A review of the quality indicators of rigor in qualitative research. American journal of pharmaceutical education, 84(1).

Jomeen, J., & Redshaw, M. (2013). Ethnic minority women's experience of maternity services in England. Ethnicity & health, 18(3), 280-296.

Jones, E., Lattof, S. R., & Coast, E. (2017). Interventions to provide culturally-appropriate maternity care services: factors affecting implementation. BMC pregnancy and childbirth, 17, 1-10.

Jones, G. L., Mitchell, C. A., Hirst, J. E., Anumba, D. O., & Royal College of Obstetricians and Gynaecologists. (2022). Understanding the relationship between social determinants of health and maternal mortality: Scientific Impact Paper No. 67. BJOG: An International Journal of Obstetrics & Gynaecology.

Jonker, L., Cox, D., & Marshall, G. (2011). Considerations, clues, and challenges: gaining ethical and trust research approval when using the NHS as a research setting. Radiography, 17(3), 260-264.

Jordal, M., & Wahlberg, A. (2018). Challenges in providing quality care for women with female genital cutting in Sweden–A literature review. Sexual & Reproductive Healthcare, 17, 91-96.

Kacperck, L. (1997). Non-verbal communication: the importance of listening. British Journal of Nursing, 6(5), 275-279.

Kahlke, R. (2018). Reflection/Commentary on a Past Article:“Generic Qualitative Approaches: Pitfalls and Benefits of Methodological Mixology” http://journals. sagepub.

com/doi/full/10.1177/160940691401300119. International Journal of Qualitative Methods, 17(1), 1609406918788193.

Kahlke, R. M. (2014). Generic qualitative approaches: Pitfalls and benefits of methodological mixology. International journal of qualitative methods, 13(1), 37-52.

Kallio, H., Pietilä, A. M., Johnson, M., & Kangasniemi, M. (2016). Systematic methodological review: developing a framework for a qualitative semi-structured interview guide. Journal of advanced nursing, 72(12), 2954-2965.

Kamal, S. S. L. B. A. (2019). Research paradigm and the philosophical foundations of a qualitative study. PEOPLE: International Journal of Social Sciences, 4(3), 1386-1394.

Kamanzi, A., & Romania, M. (2019). Rethinking confidentiality in qualitative research in the era of big data. American Behavioral Scientist, 63(6), 743-758.

Kandel, B. (2020). Qualitative Versus Quantitative Research. Journal of Product Innovation Management, 32(5), 658.

Keen, S., Lomeli-Rodriguez, M., & Joffe, H. (2022). From challenge to opportunity: virtual qualitative research during COVID-19 and beyond. International Journal of Qualitative Methods, 21, 16094069221105075.

Keikelame, M. J., & Swartz, L. (2019). Decolonising research methodologies: lessons from a qualitative research project, cape town, South Africa. Global health action, 12(1), 1561175.

Kerrigan, V., McGrath, S. Y., Doig, C., Herdman, R. M., Daly, S., Puruntatameri, P., ... & Ralph, A. P. (2024). Evaluating the impact of 'Ask the Specialist Plus': a training program for improving cultural safety and communication in hospital-based healthcare. BMC Health Services Research, 24(1), 119.

Kesinger, E. A., & Ford, J. H. (2020). Retrieval of emotional events from memory. Annual review of psychology, 71, 251-272.

Khupe, C., & Keane, M. (2017). Towards an African education research methodology: Decolonising new knowledge. Educational Research for Social Change, 6(1), 25-37.

Kidd, P. S., & Parshall, M. B. (2000). Getting the focus and the group: enhancing analytical rigor in focus group research. Qualitative health research, 10(3), 293-308.

King, N., Brooks, J., & Horrocks, C. (2018). Interviews in qualitative research.2nd, Thousand Oaks! CA: Sage.

King, C., Murillo, E., Wei, W., Madera, J., Tews, M. J., Israeli, A. A., & Kong, L. (2019). Towards a shared understanding of the service experience–a hospitality stakeholder approach. Journal of Service Management, 30(3), 410-428.

Kirkup, B. (2015). The Report of the Morecambe Bay Investigation. The Stationery Office. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/408480/47487_MBI_Accessible_v0.1.pdf

Kirmayer, L. J., Rousseau, C., Eric Jarvis, G., & Guzder, J. (2015). The cultural context of clinical assessment. Psychiatry, 56-70.

Kleinheksel, A. J., Rockich-Winston, N., Tawfik, H., & Wyatt, T. R. (2020). Demystifying content analysis. American journal of pharmaceutical education, 84(1).

Klykken, F. H. (2022). Implementing continuous consent in qualitative research. Qualitative Research, 22(5), 795-810.

Knight M, Bunch K, Felker A, Patel R, Kotnis R, Kenyon S, Kurinczuk JJ (Eds.). (2023). on behalf of MBRRACE-UK. *Saving Lives, Improving Mothers' Care Core Report - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2019-21*. Oxford: National Perinatal Epidemiology Unit, University of Oxford 2023.

Knight M, Bunch K, Patel R, Shakespeare J, Kotnis R, Kenyon S, Kurinczuk JJ (Eds.). .(2022). on behalf of MBRRACE-UK. *Saving Lives, Improving Mothers' Care Core Report - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries*

into Maternal Deaths and Morbidity 2018-20. Oxford: National Perinatal Epidemiology Unit, University of Oxford 2022.

Knight M, Bunch K, Tuffnell D, Jayakody H, Shakespeare J, Kotnis R, Kenyon S, Kurinczuk JJ (Eds.). (2018). on behalf of MBRRACE-UK. *Saving Lives, Improving Mothers' Care - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2014-16*. Oxford: National Perinatal Epidemiology Unit, University of Oxford 2018

Knight M, Bunch K, Tuffnell D, Patel R, Shakespeare J, Kotnis R, Kenyon S, Kurinczuk JJ (Eds.) .(2021). on behalf of MBRRACE-UK. *Saving Lives, Improving Mothers' Care - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2017-19*. Oxford: National Perinatal Epidemiology Unit, University of Oxford 2021.

Knight M, Bunch K, Tuffnell D, Shakespeare J, Kotnis R, Kenyon S, Kurinczuk JJ (Eds.) .(2019). on behalf of MBRRACE-UK. *Saving Lives, Improving Mothers' Care - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015-17*. Oxford: National Perinatal Epidemiology Unit, University of Oxford 2019.

Knight, M. Kenyon, S. Brocklehurst, P. Neilson, J. Shakespeare, J. Kurinczuk, J.J . (Eds.) .(2014). on behalf of MBRRACE-UK. *Saving Lives, Improving Mothers' Care - Lessons learned to inform future maternity care from the UK and Ireland Confidential Enquiries into*

Maternal Deaths and Morbidity 2009–12. Oxford: National Perinatal Epidemiology Unit, University of Oxford.

Knight M, Nair M, Tuffnell D, Shakespeare J, Kenyon S, Kurinczuk JJ (Eds.) .(2017). on behalf of MBRRACE-UK. *Saving Lives, Improving Mothers' Care - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2013–15*. Oxford: National Perinatal Epidemiology Unit, University of Oxford 2017.

Knight, M. Tuffnell, D. Kenyon, S. Shakespeare, J. Gray, R. Kurinczuk, J.J. (Eds.) .(2016). on behalf of MBRRACE-UK. *Saving Lives, Improving Mothers' Care - Surveillance of maternal deaths in the UK 2012-14 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2012-14*. Oxford: National Perinatal Epidemiology Unit, University of Oxford.

Knight, M. Tuffnell, D. Kenyon, S. Shakespeare, J. Gray, R. Kurinczuk, J.J. (Eds.). (2020). on behalf of MBRRACE-UK. *Saving Lives, Improving Mothers' Care - Surveillance of maternal deaths in the UK 2016-18 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18*. Oxford: National Perinatal Epidemiology Unit, University of Oxford.

Konje, J. K., & Konje, J. C. (2021). Experiences of accessing maternity care in the UK: Perspectives from Somali migrant women in Leicester. European Journal of Midwifery, 5.

Kovach, M. (2021). Indigenous methodologies: Characteristics, conversations, and contexts. University of Toronto press.

Kramer-Kile, M. L. (2012). RESEARCH COLUMN. Situating Methodology within Qualitative Research. Canadian Journal of Cardiovascular Nursing, 22(4).

Krueger, R. A. (2014). Focus groups: A practical guide for applied research. Sage publications.

Kruger, L. J., Rodgers, R. F., Long, S. J., & Lowy, A. S. (2019). Individual interviews or focus groups? Interview format and women's self-disclosure. International Journal of Social Research Methodology, 22(3), 245-255.

Kubukeli, P. S. (1999). Traditional healing practice using medicinal herbs. The lancet, 354, SIV24.

Kumar, M. (2006). Constructivist epistemology in action. The Journal of Educational Thought (JET)/Revue de la Pensée Educative, 247-261.

Kvale, S. (2006). Dominance through interviews and dialogues. Qualitative inquiry, 12(3), 480-500

Kwame, A., & Petrucka, P. M. (2021). A literature-based study of patient-centered care and communication in nurse-patient interactions: barriers, facilitators, and the way forward. BMC nursing, 20(1), 158.

Kyngäs, H., Kääriäinen, M., & Elo, S. (2020). The trustworthiness of content analysis. The application of content analysis in nursing science research, 41-48.

LaDonna, K. A., Artino Jr, A. R., & Balmer, D. F. (2021). Beyond the guise of saturation: rigor and qualitative interview data. Journal of Graduate Medical Education, 13(5), 607-611.

LaFromboise, T., Coleman, H.L. and Gerton, J., 1993. Psychological impact of biculturalism: Evidence and theory. Psychological bulletin, 114(3), p.395.

Lambert, V. A., & Lambert, C. E. (2012). Qualitative descriptive research: An acceptable design. Pacific Rim International Journal of Nursing Research, 16(4), 255-256

Laterza, V., Evans, D., Davies, R., Donald, C., & Rice, C. (2016). What's in a "research passport"? A collaborative autoethnography of institutional approvals in public involvement in research. Research Involvement and Engagement, 2(1), 1-22.

Lau, J. C. S. (2016). Racial Disparity in Healthcare: Universal Healthcare is not Enough. Asia Pacific J. Health L. & Ethics, 10, 173.

Laverty, M., McDermott, D. R., & Calma, T. (2017). Embedding cultural safety in Australia's main health care standards. The Medical Journal of Australia, 207(1), 15-16.

Lebano, A., Hamed, S., Bradby, H., Gil-Salmerón, A., Durá-Ferrandis, E., Garcés-Ferrer, J., ... & Linos, A. (2020). Migrants' and refugees' health status and healthcare in Europe: a scoping literature review. BMC public health, 20(1), 1-22.

Lederle, M., Tempes, J., & Bitzer, E. M. (2021). Application of Andersen's behavioural model of health services use: a scoping review with a focus on qualitative health services research. BMJ open, 11(5), e045018.

Leininger M. (1997). Transcultural nursing research to transform nursing education and practice: 40 years, Journal of Nursing Scholarship. 29(4):341-348

Leininger, M. (2002). Culture care theory: A major contribution to advance transcultural nursing knowledge and practices. *Journal of transcultural nursing*, *13*(3), 189-192.

Lekas, H. M., Pahl, K., & Fuller Lewis, C. (2020). Rethinking cultural competence: Shifting to cultural humility. Health services insights, 13, 1178632920970580.

Lenton, L. A., Smith, V., Bacon, A. M., May, J., & Charlesford, J. (2021). Ethical considerations for committees, supervisors and student researchers conducting qualitative research with young people in the United Kingdom. Methods in Psychology, 5, 100050.

Levin-Zamir, D., Leung, A. Y. M., Dodson, S., & Rowlands, G. (2017). Health literacy in selected populations: Individuals, families, and communities from the international and cultural perspective. Information Services & Use, 37(2), 131-151.

Lewis, G. (2007). The Confidential Enquiry into Maternal and Child Health (CEMACH). *Saving Mothers' Lives: reviewing maternal deaths to make motherhood safer - 2003-2005. The Seventh Report on Confidential Enquiries into Maternal Deaths in the United Kingdom.* London: CEMACH.

Li, S. S., Liddell, B. J., & Nickerson, A. (2016). The relationship between post-migration stress and psychological disorders in refugees and asylum seekers. Current psychiatry reports, 18, 1-9.

Liao, K. Y. H., Wei, M., & Yin, M. (2020). The misunderstood schema of the strong Black woman: Exploring its mental health consequences and coping responses among African American women. Psychology of Women Quarterly, 44(1), 84-104.

Lincoln, Y. S., & Guba, E. G. (1986). But is it rigorous? Trustworthiness and authenticity in naturalistic evaluation. New directions for program evaluation, 1986(30), 73-84.

Lister, R. L., Drake, W., Scott, B. H., & Graves, C. (2019). Black maternal mortality-the elephant in the room. World journal of gynecology & womens health, 3(1).

Lo, F. Y., Rey-Martí, A., & Botella-Carrubi, D. (2020). Research methods in business: Quantitative and qualitative comparative analysis. Journal of Business Research, 115, 221-224.

Lobe, B. (2017). Best practices for synchronous online focus groups. A new era in focus group research: Challenges, innovation, and practice, 227-250.

Lobe, B., Morgan, D., & Hoffman, K. A. (2020). Qualitative data collection in an era of social distancing. International journal of qualitative methods, 19, 1609406920937875.

Lokugamage, A. U., Rix, E. L., Fleming, T., Khetan, T., Meredith, A., & Hastie, C. R. (2023). Translating cultural safety to the UK. Journal of Medical Ethics, 49(4), 244-251.

Lombard, M. (2023). The experience of precarity: low-paid economic migrants' housing in Manchester. Housing Studies, 38(2), 307-326.

London Datastore. (2015). Round population projections. https://data.london.gov.uk/

London Datastore. (2019). Births by Mother's Country of Birth in London. https://data.london.gov.uk/dataset/births-by-mothers-country-of-birth-in-london

Long, H. A., French, D. P., & Brooks, J. M. (2020). Optimising the value of the critical appraisal skills programme (CASP) tool for quality appraisal in qualitative evidence synthesis. Research Methods in Medicine & Health Sciences, 1(1), 31-42.

Lorrain, S. E. (2020). Technostress from email: A case study(Doctoral dissertation, Grand Canyon University).

Luchini, C., Veronese, N., Nottegar, A., Shin, J. I., Gentile, G., Granziol, U., ... & Solmi, M. (2021). Assessing the quality of studies in meta-research: Review/guidelines on the most important quality assessment tools. Pharmaceutical statistics, 20(1), 185-195.

Lyons, S. M., O'Keeffe, F. M., Clarke, A. T., & Staines, A. (2008). Cultural diversity in the Dublin maternity services: the experiences of maternity service providers when caring for ethnic minority women. Ethnicity and Health, 13(3), 261-276.

MacKenzie, L., & Hatala, A. (2019). Addressing culture within healthcare settings: the limits of cultural competence and the power of humility. Canadian medical education journal, 10(1), e124.

Mackenzie, L., & Wallace, M. (2011). The communication of respect as a significant dimension of cross-cultural communication competence. Cross-Cultural Communication, 7(3), 10-18.

MacLellan, J., Collins, S., Myatt, M., Pope, C., Knighton, W., & Rai, T. (2022). Black, Asian and minority ethnic women's experiences of maternity services in the UK: A qualitative evidence synthesis. Journal of Advanced Nursing, 78(7), 2175-2190.

MacLellan, J., McNiven, A., & Kenyon, S. (2024) Provision of interpreting support for cross-cultural communication in UK maternity services. A freedom of information request. International Journal of Nursing Studies, *6, 100162.*

MacLeod, R., & Lewis, M. J. (Eds.). (2022). Disease, medicine, and empire: perspectives on Western medicine and the experience of European expansion. Routledge.

MacMillan, F., McBride, K. A., George, E. S., & Steiner, G. Z. (2019). Conducting a systematic review: A practical guide. Handbook of Research Methods in Health Social Sciences. Singapore: Springer Singapore, 805-17.

Madden, R. (2022). Being ethnographic: A guide to the theory and practice of ethnography. London: Sage Publications.

Madziva, C., & Chinouya, M. J. (2020). Clay Ingestion during pregnancy among Black African Women in a North London Borough: understanding cultural meanings, integrating Indigenous and biomedical knowledge systems. Frontiers in Sociology, 5, 20.

Magee, D., Bramble, M., Randell-Moon, H., Stewart-Bugg, J., & Grant, J. (2024). Understanding and responding to racism and the provision of culturally safe care by interdisciplinary health professionals in the aged care sector in regional, rural, and remote areas: a scoping review. Rural and Remote Health, 24(1), 1-9.

Malmqvist, J., Hellberg, K., Möllås, G., Rose, R., & Shevlin, M. (2019). Conducting the pilot study: A neglected part of the research process? Methodological findings supporting the importance of piloting in qualitative research studies. International journal of qualitative methods, 18, 1609406919878341.

Malterud, K., Siersma, V. D., & Guassora, A. D. (2016). Sample size in qualitative interview studies: guided by information power. Qualitative health research, 26(13), 1753-1760.

Malterud, K., Siersma, V., & Guassora, A. D. (2021). Information power: Sample content and size in qualitative studies. In P. M. Camic (Ed.), Qualitative research in psychology: Expanding perspectives in methodology and design (pp. 67–81). American Psychological Association. https://doi.org/10.1037/0000252-004

Manstead, A. S. (2018). The psychology of social class: How socioeconomic status impacts thought, feelings, and behaviour. British Journal of Social Psychology, 57(2), 267-291.

Maragh-Bass, A. C., Torain, M., Adler, R., Ranjit, A., Schneider, E., Shields, R. Y., ... & Haider, A. H. (2017). Is it okay to ask: transgender patient perspectives on sexual orientation and gender identity collection in healthcare. Academic Emergency Medicine, 24(6), 655-667.

Marcelin, J. R., Siraj, D. S., Victor, R., Kotadia, S., & Maldonado, Y. A. (2019). The impact of unconscious bias in healthcare: how to recognize and mitigate it. The Journal of infectious diseases, 220(Supplement_2), S62-S73.

Markey, K., Tilki, M., & Taylor, G. (2018). Understanding nurses' concerns when caring for patients from diverse cultural and ethnic backgrounds. Journal of clinical nursing, 27(1-2), e259-e268.

Mason. J. (2010). Sample size saturation in PhD studies using qualitative interviews, Forum: Qualitative Social Research, 11(3) Art *.

Mason-Bish, H. (2019). The elite delusion: reflexivity, identity, and positionality in qualitative research. Qualitative Research, 19(3), 263-276.

Mattelaer, J. J. (2005). The aging male in African ethnic cultures. The Aging Male, 8(1), 42-47.

Maxwell, J. A. (2008). Designing a qualitative study (Vol. pp. 214-253). The SAGE handbook of applied social research methods.

MBRRACE-UK Collaboration. (2022). A national cohort study and confidential enquiry to investigate ethnic disparities in maternal mortality. EClinicalMedicine, 43, 101237.

McCormack, C. (2004). Storying stories: a narrative approach to in-depth interview conversations. International journal of social research methodology, 7(3), 219-236.

McDonagh, M., Peterson, K., Raina, P., Chang, S., & Shekelle, P. (2013). Avoiding bias in selecting studies. Methods guide for effectiveness and comparative effectiveness reviews [Internet].

McKenna, L., Brown, T., Oliaro, L., Williams, B., & Williams, A. (2020). Listening in health care. The handbook of listening, 373-383.

McKim, C. (2023). Meaningful Member-Checking: A Structured Approach to Member-Checking. American Journal of Qualitative Research, 7(2), 41-52.

McKnight, P., Goodwin, L., & Kenyon, S. (2019). A systematic review of asylum-seeking women's views and experiences of UK maternity care. Midwifery, 77, 16-23.

McLemore, M. R., Altman, M. R., Cooper, N., Williams, S., Rand, L., & Franck, L. (2018). Health care experiences of pregnant, birthing, and postnatal women of color at risk for preterm birth. Social Science & Medicine, 201, 127-135.

McSweeney, B. (2021). Fooling ourselves and others: confirmation bias and the trustworthiness of qualitative research–Part 1 (the threats). Journal of Organizational Change Management, 34(5), 1063-1075.

Meidert, U., Dönnges, G., Bucher, T., Wieber, F., & Gerber-Grote, A. (2023). Unconscious Bias among health professionals: a scoping review. International journal of environmental research and public health, 20(16), 6569.

Mes, M. A., Chan, A. H. Y., Wileman, V., Katzer, C. B., Goodbourn, M., Towndrow, S., ... & Horne, R. (2019). Patient involvement in questionnaire design: tackling response error and burden. Journal of pharmaceutical policy and practice, 12(1), 1-4.

Metelli, S., & Chaimani, A. (2020). Challenges in meta-analyses with observational studies. Evidence-based mental health, 23(2), 83-87.

Methley, A. M., Campbell, S., Chew-Graham, C., McNally, R., & Cheraghi-Sohi, S. (2014). PICO, PICOS and SPIDER: a comparison study of specificity and sensitivity in three search tools for qualitative systematic reviews. BMC health services research, 14(1), 1-10.

Miki, Y., Chubachi, N., Imamura, F., Yaegashi, N., & Ito, K. (2020). Impact of COVID-19 restrictions on the research environment and motivation of researchers in Japan. Progress in disaster science, 8, 100128.

Miles, M. B., & Huberman, A. M. (1994). Qualitative data analysis: An expanded sourcebook. sage.

Moeti, C., Mulaudzi, F. M., & Rasweswe, M. M. (2023). The Disposal of Placenta among Indigenous Groups Globally: An Integrative Literature Review. International Journal of Reproductive Medicine, 2023.

Mohale, H., Sweet, L., & Graham, K. (2017). Maternity health care: the experiences of sub-Saharan African women in sub-Saharan Africa and Australia. Women and Birth, 30(4), 298-307.

Moher, D., Liberati, A., Tetzlaff, J., Altman, D. G., & PRISMA Group*, T. (2009). Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. Annals of internal medicine, 151(4), 264-269.

Moher, D., Shamseer, L., Clarke, M., Ghersi, D., Liberati, A., Petticrew, M., ... & Prisma-P Group. (2015). Preferred reporting items for systematic review and meta-analysis protocols (PRISMA-P) 2015 statement. Systematic reviews, 4, 1-9.

Molina, J. G., Rodrigo, M. F., Losilla, J. M., & Vives, J. (2014). Wording effects and the factor structure of the 12-item General Health Questionnaire (GHQ-12). Psychological assessment, 26(3), 1031.

Möller, C., Passam, S., Riley, S., & Robson, M. (2024). All inside our heads? A critical discursive review of unconscious bias training in the sciences. Gender, Work & Organization, 31(3), 797-820.

Morgan, D. L. (2009). Focus groups as qualitative research (2nd ed.). Thousand Oaks, CA: Sage

Moreau, K. A., Giroux, C. M., & Eady, K. (2023). 5 Involving stakeholders. Starting Research in Clinical Education, 39.

Morrow, R., Rodriguez, A., & King, N. (2015). Colaizzi's descriptive phenomenological method. The psychologist, 28(8), 643-644.

Morse, J. M. (2008). Confusing categories and themes. Qualitative health research, 18(6), 727-728.

Morse, J. M. (2015). Data were saturated... Qualitative health research, 25(5), 587-588.

Morse, W. C., Lowery, D. R., & Steury, T. (2014). Exploring saturation of themes and spatial locations in qualitative public participation geographic information systems research. Society & Natural Resources, 27(5), 557-571.

Moscrop, A., Ziebland, S., Roberts, N., & Papanikitas, A. (2019). A systematic review of reasons for and against asking patients about their socioeconomic contexts. International journal for equity in health, 18, 1-15.

Moser, A. & Korstjens, I. (2018). Series. Practical guidance to qualitative research. Part 3: Sampling, data collection and analysis, European Journal of General Practice. Dec; 24 (1): 9-18.

Mourad, M., Bousleiman, S., Wapner, R., & Gyamfi-Bannerman, C. (2020). Conducting research during the COVID-19 pandemic. In Seminars in perinatology (Vol. 44, No. 7, p. 151287). WB Saunders.

Murray, L., Windsor, C., Parker, E., & Tewfik, O. (2010). The experiences of African women giving birth in Brisbane, Australia. Health Care for Women International, 31(5), 458-472.

Myers, K. R., Tham, W. Y., Yin, Y., Cohodes, N., Thursby, J. G., Thursby, M. C., ... & Wang, D. (2020). Unequal effects of the COVID-19 pandemic on scientists. Nature human behaviour, 4(9), 880-883.

Nair, M. Kurinczuk, J.J. Knight, N. (2014a). Ethnic variations in severe maternal morbidity in the UK- A case control study. PLoS ONE 9, Retrieved from (4):e95086. Doi:10.1371/journal.pone.0095086

Nair, M., Yoshida, S., Lambrechts, T., Boschi-Pinto, C., Bose, K., Mason, E. M., & Mathai, M. (2014b). Facilitators and barriers to quality of care in maternal, newborn and child health: a global situational analysis through metareview. BMJ open, 4(5), e004749.

Nakagawa, S. (2017). Indigenous Research Methodology and the Indigenous Academic. The Canadian Journal of Native Studies, 37, 95-115.

Namey, E., Guest, G., McKenna, K., & Chen, M. (2016). Evaluating bang for the buck: a cost-effectiveness comparison between individual interviews and focus groups based on thematic saturation levels. American Journal of Evaluation, 37(3), 425-440

National Institute for Health Research. (2020). DHSC issues guidance on the impact of COVID-19 on research funded or supported by NIHR, updated 19 Mar 2020. https://www.nihr.ac.uk/news/dhsc-issues-guidance-on-the-impact-on-covid-19-on-research-funded-or-supported-by-nihr/24469

Ndirangu, E. W., & Evans, C. (2009). Experiences of African immigrant women living with HIV in the UK: implications for health professionals. Journal of Immigrant and Minority Health, 11, 108-114.

Neergaard, M. A., Olesen, F., Andersen, R. S., & Sondergaard, J. (2009). Qualitative description–the poor cousin of health research?. BMC medical research methodology, 9(1), 52.

Nellums, L.B., Powis, J., Jones, L., Miller, A., Rustage, K., Russell, N., Friedland, J.S. and Hargreaves, S., (2021). “It's a life you're playing with”: A qualitative study on experiences of NHS maternity services among undocumented migrant women in England. Social Science & Medicine, 270, p.113610.

Nelson, T., Cardemil, E. V., & Adeoye, C. T. (2016). Rethinking strength: Black women's perceptions of the "Strong Black Woman" role. Psychology of women quarterly, 40(4), 551-563.

Neubauer, B. E., Witkop, C. T., & Varpio, L. (2019). How phenomenology can help us learn from the experiences of others. Perspectives on medical education, 8, 90-97.

Newman, A. M. (2022). Moving beyond mistrust: Centering institutional change by decentering the white analytical lens. Bioethics, 36(3), 267-273.

Ngongalah, L., Rapley, T., Rankin, J., & Heslehurst, N. (2023). Cultural Influences on African Migrant Pregnant and Postnatal Women's Dietary Behaviours and Nutrition Support Needs in the UK. Nutrients, 15(19), 4135.

NHS England. (2016). Better births. Improving outcomes of maternity services in England, A five year forward plan, NHS England. https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

NHS England (2023) Increasing Diversity in Research Participation, A good practice guide for engaging with underrepresented groups https://www.england.nhs.uk/aac/wp-content/uploads/sites/50/2023/02/B1905-increasing-diversity-in-research-participation.pdf.

NHS England. (2024). Enabling people to make informed health decisions. https://www.england.nhs.uk/personalisedcare/health-literacy/

NHS RHO (2023) Promoting Effective and Respectful Communication with Ethnic Minority Women and Pregnant People, https://www.nhsrho.org/research/promoting-effective-and-respectful-communication-with-ethnic-minority-women-and-pregnant-people/

NICE (2010). Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors. https://www.nice.org.uk/guidance/cg110

NICE (2021). Antenatal Care, https://www.nice.org.uk/guidance/ng201/resources/antenatal-care-pdf-66143709695941

Nilmanat K & Kuriniawan,T. (2021). The quest in case study research. Pacific Rim International Journal of Nursing Research, 25(1), 1-6.

NMC. (2014). Extraordinary LSA review. Princess Elizabeth Hospital, Health, and Social Services Department. Retrieved from https://www.nmc.org.uk/globalassets/siteDocuments/MidwiferyExtraordinaryReviewReports/Extraordinary_Review-LSA_South_West_Guernsey__01-03-Oct_14.pdf

NMC. (2018).The Code: Professional standards of practice and behaviour for nurses, midwives, and nursing associates. https://www.nmc.org.uk/standards/code/

NMC. (2019). Standards of proficiency for midwives, https://www.nmc.org.uk/globalassets/sitedocuments/standards/standards-of-proficiency-for-midwives.pdf

NMC. (2023). Standards for preregistration midwifery programmes, https://www.nmc.org.uk/globalassets/sitedocuments/standards/standards-for-pre-registration-midwifery-programmes.pdf

Noble, H., & Smith, J. (2015). Issues of validity and reliability in qualitative research. Evidence-based nursing, 18(2), 34-35.

Noon, M. (2018). Pointless diversity training: Unconscious bias, new racism, and agency. Work, employment and society, 32(1), 198-209.

Nordstrom, S.N. (2015). Not so innocent anymore: Making recording devices matter in qualitative interviews. Qualitative Inquiry, 21(14), 388-40.

Nulty, D. D. (2008). The adequacy of response rates to online and paper surveys: what can be done?. Assessment & evaluation in higher education, 33(3), 301-314.

Nursing Council of New Zealand. 2011. Guidelines for cultural safety, the Treaty of Waitangi and Maori Health in Nursing Education and Practice, Nursing Council of New Zealand 2011. Wellington, New Zealand.

Oche, O. M., Kontagora, Z. A., Danmadami, A. M., Umar, B. B., Dabai, U. L., & Ayama, Y. A. (2024). Disrespect and abuse of women during childbirth in selected health facilities in Sokoto metropolis, Nigeria. Ibom Medical Journal, 17(1), 91-102.

Ockenden, D. (2022). Ockenden review: summary of findings, conclusions, and essential actions. https://www.gov.uk/government/publications/final-report-of-the-ockenden-review

O'Connor, A., & Sargeant, J. (2015). Research synthesis in veterinary science: narrative reviews, systematic reviews, and meta-analysis. The Veterinary Journal, 206(3), 261-267.

O'Hagan, K. (2001). Cultural competence in the caring professions. J Kingsley. London.

Ohaja, M., & Anyim, C. (2021). Rituals and embodied cultural practices at the beginning of life: African perspectives. Religions, 12(11), 1024.

Ojua, T., Ishor, D., & Ndom, P. (2013). African cultural practices and health implications for Nigeria rural development. International review of management and business research, 2(1).

Olajide, O. A. (2014). Migration: its causes and consequences in south east Nigeria. In African Dynamics in a Multipolar World: 5th European Conference on African Studies—Conference Proceedings (pp. 1637-1650). Centro de Estudos Internacionais do Instituto Universitário de Lisboa (ISCTE-IUL).

Omonzejele, P. F. (2008). African concepts of health, disease, and treatment: An ethical inquiry. Explore, 4(2), 120-126.

ONS. (2016). Birth by parents' country of birth, England, and Wales: 2015. https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/bulletins/parentscountryofbirthenglandandwales/2015

ONS. (2019). International Passenger Survey 4.05, main reason for migration by country of last or next residence, https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/internationalmigration/datasets/ipsmainreasonformigrationbycountryoflastornextresidence

ONS. (2021a). Population of England and Wales, https://www.ethnicity-facts-figures.service.gov.uk/uk-population-by-ethnicity/national-and-regional-populations/population-of-england-and-wales/latest/

ONS (2021b). Language, England and Wales: Census 2021, https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/language/bulletins/languageenglandandwales/census2021#main-languages-within-households

ONS (2023) How qualification levels across England and Wales differ by country of birth. https://www.ons.gov.uk/peoplepopulationandcommunity/educationandchildcare/articles/howqualificationlevelsacrossenglandandwalesdifferbycountryofbirth/2023-05-15

Opel, D. J., Lo, B., & Peek, M. E. (2021). Addressing mistrust about COVID-19 vaccines among patients of color. Annals of Internal Medicine, 174(5), 698-700.

Opondo, C., Jayaweera, H., Hollowell, J., Li, Y., Kurinczuk, J., & Quigley, M. (2020). Variations in neonatal mortality, infant mortality, preterm birth and birthweight in England and Wales according to maternal country or region of birth: an analysis of linked national data from 2006 to 2012. Journal of Epidemiology and Community Health, 74(4).

O'Reilly, M., & Parker, N. (2013). 'Unsatisfactory Saturation': a critical exploration of the notion of saturated sample sizes in qualitative research. Qualitative research, 13(2), 190-197.

Origlia Ikhilor, P., Hasenberg, G., Kurth, E., Asefaw, F., Pehlke-Milde, J., & Cignacco, E. (2019). Communication barriers in maternity care of allophone migrants: Experiences of women, healthcare professionals, and intercultural interpreters. Journal of advanced nursing, 75(10), 2200-2210.

Orpin, J., Puthussery, S., Davidson, R., & Burden, B. (2018). Women's experiences of disrespect and abuse in maternity care facilities in Benue State, Nigeria. BMC pregnancy and childbirth, 18, 1-9.

Osayemwenre, O. B., Olayemiomolola, C. O., & Faith, M. (2023). Nigeria Pattern of Migration: Issues on Human Sustainable Development. Journal of Techno-Social, 15(1), 1-15.

Oscarsson, M. G., & Stevenson-Ågren, J. (2020). Midwives' experiences of caring for immigrant women at antenatal care. Sexual & Reproductive Healthcare, 24, 100505.

Paez, A. (2017). Gray literature: An important resource in systematic reviews. Journal of Evidence-Based Medicine, 10(3), 233-240.

Palinkas, L. A., Horwitz, S. M., Green, C. A., Wisdom, J. P., Duan, N., & Hoagwood, K. (2015). Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. Administration and policy in mental health and mental health services research, 42(5), 533-544.

Pangas, J., Ogunsiji, O., Elmir, R., Raman, S., Liamputtong, P., Burns, E., ... & Schmied, V. (2019). Refugee women's experiences negotiating motherhood and maternity care in a new country: A meta-ethnographic review. International Journal of Nursing Studies, 90, 31-45.

Papadopoulos, I. (Ed.). (2006). Transcultural health and social care: development of culturally competent practitioners. Elsevier Health Sciences

Papadopoulos, I. Tilki, M. & Taylor, G. (1998). Transcultural care: a guide for health care professionals. London: Quay books.

Parisa, B., Reza, N., Afsaneh, R., & Sarieh, P. (2016). Cultural safety: an evolutionary concept analysis. Holistic nursing practice, 30(1), 33-38.

Parrish, S., Vasan, S. K., Karpe, F., Hardy-Johnson, P., Jarjou, O., Bittaye, M., ... & Jobe, M. (2023). Concealed pregnancy as an act of care? A qualitative analysis of motivations for concealing and non-disclosure of early pregnancy in The Gambia. BMC Pregnancy and Childbirth, 23(1), 374.

Patel, P., Bernays, S., Dolan, H., Muscat, D. M., & Trevena, L. (2021). Communication experiences in primary healthcare with refugees and asylum seekers: a literature review and narrative synthesis. International journal of environmental research and public health, 18(4), 1469.

Paternotte, E., van Dulmen, S., van der Lee, N., Scherpbier, A. J., & Scheele, F. (2015). Factors influencing intercultural doctor–patient communication: A realist review. Patient education and counseling, 98(4), 420-445

Pathak, N., Zhang, C. X., Boukari, Y., Burns, R., Menezes, D., Hugenholtz, G., ... & Aldridge, R. W. (2024). Sexual and reproductive health and rights of migrant women attending primary care in England: A population-based cohort study of 1.2 million individuals of reproductive age (2009–2018). Journal of Migration and Health, 9, 100214.

Pati, D., & Lorusso, L. N. (2018). How to write a systematic review of the literature. HERD: Health Environments Research & Design Journal, 11(1), 15-30.

Pemberton, S., Phillimore, J., & Robinson, D. (2014). Causes and experiences of poverty among economic migrants in the UK. University of Birmingham IriS WP 4.

Percy, W. H., Kostere, K., & Kostere, S. (2015). Generic qualitative research in psychology. The qualitative report, 20(2), 76-85.

Peter, M, & Wheeler, R. (2022). The Black maternity experiences survey. A nationwide study of Black women's experiences of maternity services in the United Kingdom.

Pew Research Center. (2022). One-in-Ten Black People Living in the U.S. Are Immigrants. Retrieved from https:// www. pewresearch. org/ race- ethnicity/ 2022c/ 01/ 20/ one- in- ten-black- people- living- in- the-u-s-are-immigrants/

Phillimore, J. (2016). Migrant maternity in an era of superdiversity: new migrants' access to, and experience of, antenatal care in the West Midlands, UK. Social Science & Medicine, 148, 152-159.

Phiri, J., Dietsch, E., & Bonner, A. (2010). Cultural safety and its importance for Australian midwifery practice. Collegian, 17(3), 105-111.

Polit, D., & Beck, C. (2020). Essentials of nursing research: Appraising evidence for nursing practice. Lippincott Williams & Wilkins.

Prescott, T. L., Phillips II, G., DuBois, L. Z., Bull, S. S., Mustanski, B., & Ybarra, M. L. (2016). Reaching adolescent gay, bisexual, and queer men online: Development and refinement of a national recruitment strategy. Journal of Medical Internet Research, 18(8), Article e200.

Public Health England.(2013)). Alert issued to pregnant women in London following reports of toxic antidote to morning sickness. https://www.gov.uk/government/news/alert-issued-to-pregnant-women-in-london-following-reports-of-toxic-antidote-to-morning-sickness

Punch, K. F. (2013). Introduction to social research: Quantitative and qualitative approaches. London: Sage.

Puthussery, S. (2016). Perinatal outcomes among migrant mothers in the United Kingdom: is it a matter of biology, behaviour, policy, social determinants, or access to health care?. Best practice & research Clinical obstetrics & gynaecology, 32, 39-49.

Rabiee, F. (2004). Focus-group interview and data analysis. Proceedings of the nutrition society, 63(4), 655-660.

Race Relations Act (Amendment) (2000). https://www.legislation.gov.uk/ukpga/2000/34/notes/division/3

Raleigh, V. S. (2023). The health of people from ethnic minority groups in England. King's Fund. https://www.kingsfund.org.uk/insight-and-analysis/long-reads/health-people-ethnic-minority-groups-england

Rangel, D. E., & Valdez, C. R. (2017). A culturally sensitive approach to large-scale prevention studies: a case study of a randomized controlled trial with low-income Latino communities. The journal of primary prevention, 38, 627-645.

Ramsden, I. (2002). Cultural safety and nursing education in Aotearoa and Te Waipounamu (Doctoral dissertation, Victoria University of Wellington).

RCOG. (2008). Standards for maternity care. https://www.rcog.org.uk/guidance/browse-all-guidance/other-guidelines-and-reports/standards-for-maternity-care/

Rees, C. E., Crampton, P. E., & Monrouxe, L. V. (2020). Re-visioning academic medicine through a constructionist lens. Academic Medicine, 95(6), 846-850.

Reeves, S., Peller, J., Goldman, J., & Kitto, S. (2013). Ethnography in qualitative educational research: AMEE Guide No. 80. Medical teacher, 35(8), e1365-e1379.

Rees, C. (2016). Rapid research methods for nurses, midwives, and health professionals. John Wiley & Sons.

Richard, B., Sivo, S. A., Orlowski, M., Ford, R. C., Murphy, J., Boote, D. N., & Witta, E. L. (2021). Qualitative research via focus groups: will going online affect the diversity of your findings?. Cornell Hospitality Quarterly, 62(1), 32-45.

Richardson, S. and McMullan, M. (2007). Research ethics in the UK: What can sociology learn from health? Sociology, 41(6), 1115-1132.

Rijnders, M., Baston, H., Schönbeck, Y., Van Der Pal, K., Prins, M. Green, J. & Buitendijk, S. (2008). Perinatal factors related to negative or positive recall of birth experience in women 3 years postpartum in the Netherlands. Birth, 35(2), 107-116.

Ritchie, J., Lewis, J., Nicholls, C. M., & Ormston, R. (Eds.). (2013). Qualitative research practice: A guide for social science students and researchers. sage.

Rodat, S. (2017). Cultural racism: a conceptual framework. Revista de Științe Politice. Revue des Sciences Politiques, (54), 129-140.

Rolstad, S., Adler, J., & Rydén, A. (2011). Response burden and questionnaire length: is shorter better? A review and meta-analysis. Value in Health, 14(8), 1101-1108.

Roos, H. (2022). Repeated interviews with students–critical methodological points for research quality. International Journal of Research & Method in Education, 45(5), 423-436.

Romm, N. R. A. (2015). Conducting focus groups in terms of an appreciation of indigenous ways of knowing: Some examples from South Africa. In Forum Qualitative Sozialforschung/Forum: Qualitative Social Research (Vol. 16, No. 1).

Rough, E. & Baker, C. (2023). Infant mortality and health inequalities. https://commonslibrary.parliament.uk/research-briefings/cbp-9904/#share-this

Rutakumwa, R., Mugisha, J. O., Bernays, S., Kabunga, E., Tumwekwase, G., Mbonye, M., & Seeley, J. (2020). Conducting in-depth interviews with and without voice recorders: a comparative analysis. Qualitative Research, 20(5), 565-581.

Ryan, L., Rodriguez, M. L., & Trevena, P. (2016, May). Opportunities and challenges of unplanned follow-up interviews: Experiences with Polish migrants in London. In Forum qualitative sozialforschung/forum: Qualitative social research (Vol. 17, No. 2).

Sagiv, L., & Schwartz, S. H. (2022). Personal values across cultures. Annual review of psychology, 73, 517-546.

Samardzic, T., Wildman, C., Barata, P. C., & Morton, M. (2023). Considerations for conducting online focus groups on sensitive topics. International Journal of Social Research Methodology, 27(4), 485–490. https://doi.org/10.1080/13645579.2023.2185985

Sam, D., & Berry, J. (2010). Acculturation: When Individuals and Groups of Different Cultural Backgrounds Meet. Perspectives on Psychological Science, 5, 472-481.

Sandelowski, M. (1986). The problem of rigor in feminist research. Advances in Nursing Science, 8(3), 27-37.

Sandelowski, M. (1993). Rigor or rigor mortis: The problem of rigor in qualitative research revisited. Advances in nursing science, 16(2), 1-8.

Sandelowski, M. (1995). Sample size in qualitative research. Research in nursing & health, 18(2), 179-183.

Sandelowski, M., (2000). Whatever happened to qualitative description?. Research in nursing & health, 23(4), pp.334-340.

Sangalang, C. C., Becerra, D., Mitchell, F. M., Lechuga-Peña, S., Lopez, K., & Kim, I. (2019). Trauma, post-migration stress, and mental health: A comparative analysis of refugees and immigrants in the United States. Journal of immigrant and minority health, 21, 909-919.

Sarantaki, A., Metallinou, D., Kyritsi, R., Diamanti, A., & Lykeridou, K. (2020). Perinatal Cultural Aspects of African Refugee Women Resettled in Greece: Providing Culturally-sensitive Midwifery Care. Materia Socio-medica, 32(4), 294.

Saunders, C. L., Abel, G. A., El Turabi, A., Ahmed, F., & Lyratzopoulos, G. (2013). Accuracy of routinely recorded ethnic group information compared with self-reported ethnicity: evidence from the English Cancer Patient Experience survey. BMJ open, 3(6), e002882.

Sawrikar, P., & Hunt, C. J. (2005). The relationship between mental health, cultural identity, and cultural values in non-English speaking background (NESB) Australian adolescents. Behaviour Change, 22(2), 97-113.

Schirmer, D. (2023). 3 Strategies to Make Your Data Collection more Patient-Centric https://climedo.de/en/blog/3-strategies-to-make-your-data-collection-more-patient-centric/

Schoch, K. (2020). Case study research. Research design and methods: An applied guide for the scholar- practitioner, 245-258.

Schouten, B. C., Cox, A., Duran, G., Kerremans, K., Banning, L. K., Lahdidioui, A., ... & Krystallidou, D. (2020). Mitigating language and cultural barriers in healthcare communication: Toward a holistic approach. Patient Education and Counseling, 103(12), 2604-2608.

Shanker, S., Wasti, S. P., Ireland, J., Regmi, P., Simkhada, P., & van Teijlingen, E. (2021). The interdisciplinary team not the interdisciplinarist: Reflections on interdisciplinary research. Europasian Journal of Medical Sciences, 3(2).

Shaw, S. J., Huebner, C., Armin, J., Orzech, K., & Vivian, J. (2009). The role of culture in health literacy and chronic disease screening and management. Journal of immigrant and minority health, 11, 460-467.

Schwartz, S.J. and Zamboanga, B.L., 2008. Testing Berry's model of acculturation: A confirmatory latent class approach. Cultural diversity and ethnic minority psychology, 14(4), p.275.

Sheikh, M. and Anderson, J.R., 2018. Acculturation patterns and education of refugees and asylum seekers: A systematic literature review. Learning and Individual Differences, 67, pp.22-32.

Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. Education for information, 22(2), 63-75.

Shen, Z. (2015). Cultural competence models and cultural competence assessment instruments in nursing: a literature review. Journal of transcultural nursing, 26(3), 308-321

Shepherd, S. M., Willis-Esqueda, C., Newton, D., Sivasubramaniam, D., & Paradies, Y. (2019). The challenge of cultural competence in the workplace: perspectives of healthcare providers. BMC health services research, 19, 1-11.

Shewamene, Z., Dune, T., & Smith, C. A. (2017). The use of traditional medicine in maternity care among African women in Africa and the diaspora: a systematic review. BMC complementary and alternative medicine, 17, 1-16.

Shorey, S., Ng, E. D., & Downe, S. (2021). Cultural competence and experiences of maternity health care providers on care for migrant women: a qualitative meta-synthesis. Birth, 48(4), 458-469.

Siedlecki, S. L. (2020). Understanding descriptive research designs and methods. Clinical Nurse Specialist, 34(1), 8-12.

Silverio, S. A., Varman, N., Barry, Z., Khazaezadeh, N., Rajasingam, D., Magee, L. A., & Matthew, J. (2023). Inside the 'imperfect mosaic': Minority ethnic women's qualitative experiences of race and ethnicity during pregnancy, childbirth, and maternity care in the United Kingdom. BMC Public Health, 23(1), 2555.

Silverman, D. (2013) Doing Qualitative Research, Sage publications: London.

Silverman, D. (2021). Doing qualitative research.6th Edition, Sage publications: London.

Sim, J., & Waterfield, J. (2019). Focus group methodology: some ethical challenges. Quality & quantity, 53(6), 3003-3022.

Simkin, P. (1991). Just another day in a woman's life? Women's long-term perceptions of their first birth experience. Part I. Birth, 18(4), 203-210.

Slevin, E., & Sines, D. (1999). Enhancing the truthfulness, consistency, and transferability of a qualitative study: utilising a manifold of approaches. Nurse Researcher (through 2013), 7(2), 79.

Solot, D., & Arluke, A. (1997). Learning the Scientist's Role: Animal Dissection in Middle School. Journal of Contemporary Ethnography, 26, 28-54.

Smith, L. T. (2021). Decolonizing Methodologies: Research and Indigenous Peoples. Zed Books.

Smith, Y. J. (2018). Traditional Dance as a vehicle for identity construction and social engagement after forced migration. *Societies*, *8*(3), 67

Squire, C., & Sookhoo, D. (2017). 'Race,' ethnicity, culture, and childbirth. In The social context of birth (pp. 69-87). Routledge.

Stadimayr, M.W. Amsler, S.L. Lemola, S.S. Stein, M.A. & Burgin, A.D. (2006). Memory of childbirth in the seon year : The long-term effect of a negative birth experience and its modulation by the perceived intranatal relationship with caregivers. Journal of Psychosomatic Obstetrics and Gynecology, 7 (4), 211-224.

Stahl, N. A., & King, J. R. (2020). Expanding approaches for research: Understanding and using trustworthiness in qualitative research. Journal of Developmental Education, 44(1), 26-28.

Stake, R.E (2000) Case studies in N. K Denzin and Y S Lincoln (Ed's) Handbook of Qualitative Research (2nd ed. Thousand Oaks, CA. Sage.

Staller, K. M. (2021). Big enough? Sampling in qualitative inquiry. Qualitative Social Work, 20(4), 897-904.

Stenfors, T., Kajamaa, A., & Bennett, D. (2020). How to… assess the quality of qualitative research. The clinical teacher, 17(6), 596-599.

Stofer, K. A. (2019). Preparing for One-on-One Qualitative Interviews: Designing and Conducting the Interview: AEC675/WC338, 8/2019. EDIS, 2019(4), 4-4.

Stone, K., Vicary, S., Scott, C., & Buckland, R. (2020). Ethical approval and being a virtuous social work researcher. The experience of multi-site research in UK health and social care: an approved mental health professional case study. Ethics and Social Welfare, 14(2), 156-171

Strauss, L. Mc Ewan, A. & Hussein, F, M. (2009). Somali women's experience of childbirth in the UK: perspectives from Somali health workers, Midwifery 25(2), 181-6

Stubbe, D. E. (2020). Practicing cultural competence and cultural humility in the care of diverse patients. Focus, 18(1), 49-51.

Sukhera, J. (2022). Narrative reviews: flexible, rigorous, and practical. Journal of Graduate Medical Education, 14(4), 414-417.

Szczepura, A. (2005). Access to health care for ethnic minority populations. Postgraduate medical journal, 81(953), 141-147.

Taherdoost, H. (2022). What are different research approaches? Comprehensive Review of Qualitative, quantitative, and mixed method research, their applications, types, and limitations. Journal of Management Science & Engineering Research, 5(1), 53-63.

Takehara, K. Noguchi, M. Shimane , T. & Misago, C. (2014). A longitudinal study of women's memories of their childbirth experiences at five years postpartum BMC Pregnancy and Childbirth. https://doi.org/10.1186/1471-2393-14-221

Tamene, E. H. (2016). Theorizing conceptual framework. Asian Journal of Educational Research Vol, 4(2), 50-56.

Tankosić, A., & Dovchin, S. (2023). (C) overt linguistic racism: Eastern-European background immigrant women in the Australian workplace. Ethnicities, 23(5), 726-757.

Tausch, A. P., & Menold, N. (2016). Methodological aspects of focus groups in health research: results of qualitative interviews with focus group moderators. Global qualitative nursing research, 3, 2333393616630466.

Taylor, G. D., & Rogers, H. (2019). How to get ethical approval for NHS-based research. BDJ Team.

Teh, Y. Y., & Lek, E. (2018). Culture and reflexivity: Systemic journeys with a British Chinese family. Journal of Family Therapy, 40(4), 520-536.

Tenny, S., Branban, J. M., & Brennan, G.D. (2022). Qualitative Study. 2022 Sep 18. StatPearls (Internet). Treasure Island (FL): StatPearls Publishing.

Teti, M., Schatz, E., & Liebenberg, L. (2020). Methods in the time of COVID-19: the vital role of qualitative inquiries. International Journal of Qualitative Methods, 19, 1609406920920962.

Thambinathan, V., & Kinsella, E. A. (2021). Decolonizing methodologies in qualitative research: Creating spaces for transformative praxis. International journal of qualitative methods, 20, 16094069211014766.

Thiel, F., Bergman, Z., Dishy, G. A., Chan, S.J, Seth, H., Tokala, M., …& Dekel, S. (2021). Traumatic memories of childbirth relate to maternal postpartum post-traumatic stress disorder. Journal of anxiety disorders, 77, 102342.

Thomas, D, R. (2003). A general inductive approach for qualitative data analysis. School of Population Health, University of Auckland, New Zealand.

Thomas, J., & Harden, A. (2008). Methods for the thematic synthesis of qualitative research in systematic reviews. BMC medical research methodology, 8, 1-10.

Thomas, S. (2012). Narrative inquiry: Embracing the possibilities. Qualitative Research Journal, 12(2), 206-221

Thomson, G., & Downe, S. (2016). Emotions and support needs following a distressing birth: Scoping study with pregnant multigravida women in North-West England. Midwifery, 40, 32-39.

Thorpe, S., Dogan-Dixon, J., Malone, N., & Palomino, K. A. (2024). ‘Just be strong and keep going’: the influence of Superwoman Schema on Black women’s perceived expectations of coping with sexual pain. Culture, Health & Sexuality, 26(3), 346-361.

Tight, M. (2023). Saturation: An Overworked and Misunderstood Concept?. Qualitative Inquiry, 10778004231183948.

Ting-Toomey, S. (1999). Communicating across cultures. New York: The Guilford Press.

Tobi, H., & Kampen, J. K. (2018). Research design: the methodology for interdisciplinary research framework. Quality & quantity, 52, 1209-1225.

Tobin, C. Murphy-Lawless, J. Beck, C.T. (2014). Childbirth in exile: asylum seeking experiences of childbirth in Ireland, Midwifery, 30(7), 831-838.

Tobin, C. L., & Murphy-Lawless, J. (2014). Irish midwives' experiences of providing maternity care to non-Irish women seeking asylum. International journal of women's health, 159-169.

Toh, R. K. C., & Shorey, S. (2023). Experiences and needs of women from ethnic minorities in maternity healthcare: A qualitative systematic review and meta-aggregation. Women and Birth, 36(1), 30-38.

Topkara, F. N., & Çağan, Ö. (2020). Examining Psychometric Properties of the Turkish Version of the Birth Memories and Recall Questionnaire. 0(0),0–0. https://doi.org/10.14744/phd.2020.60234

Tritter, J. Q., & Landstad, B. J. (2020). Focus groups. Qualitative research in health care, 57-66.

Trueba, M. L., Axelrod, T., & Ayeb-Karlsson, S. (2023). Are asylum seekers and refugees provided with appropriate mental health support in the United Kingdom?. Journal of Ethnic and Migration Studies, 49(13), 3163-3183.

Turner, D.W. (2010). Qualitative interview design: a practical guide for novice investigators, The Qualitative Report, 15(3), 754-760.

Turner, C., & Astin, F. (2021). Grounded theory: what makes a grounded theory study?. European Journal of Cardiovascular Nursing, 20(3), 285-289.

Turner III, D. W., & Hagstrom-Schmidt, N. (2022). Qualitative interview design. Howdy or Hello? Technical and Professional Communication.

Ukoko, F. (2005). Sure start midwife: giving a voice to the voiceless. British Journal of Midwifery, 13(12), 776-780.

UNFPA. (2010). Reducing maternal mortality, Human Rights Centre, University of Essex.

Unger, J. B., Gallaher, P., Shakib, S., Ritt-Olson, A., Palmer, P. H., & Johnson, C. A. (2002). The AHIMSA acculturation scale: A new measure of acculturation for adolescents in a multicultural society. The Journal of Early Adolescence, 22(3), 225-251.

Vaismoradi, M. Turunen, H. & Bondas, T. (2013). Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study. Nursing & health sciences, 15(3), 398-405.

Vanderkruik, R. C., Tunçalp, Ö., Chou, D., & Say, L. (2013). Framing maternal morbidity: WHO scoping exercise. BMC pregnancy and childbirth, 13(1), 1-7.

Van der Ven, L. G. L., van Baar, J. M., Wispelweij, R. S., & Jambroes, M. (2022). How to involve ‘hard to reach’population groups in research projects. European Journal of Public Health, 32(Supplement_3), ckac129-476.

Van Manen, M. (2017). But is it phenomenology?. Qualitative health research, 27(6), 775-779.

van Tienoven, T. P., Glorieux, A., Minnen, J., Te Braak, P., & Spruyt, B. (2022). Graduate students locked down? PhD students’ satisfaction with supervision during the first and second COVID-19 lockdown in Belgium. Plos one, 17(5), e0268923.

Varpio, L., Ajjawi, R., Monrouxe, L. V., O'Brien, B. C., & Rees, C. E. (2017). Shedding the cobra effect: problematising thematic emergence, triangulation, saturation, and member checking. Medical education, 51(1), 40-50.

Varpio, L., Paradis, E., Uijtdehaage, S., & Young, M. (2020). The distinctions between theory, theoretical framework, and conceptual framework. Academic medicine, 95(7), 989-994.

Vears, D. F., & Gillam, L. (2022). Inductive content analysis: A guide for beginning qualitative researchers. Focus on Health Professional Education: A Multi-Professional Journal, 23(1), 111-127.

Villarosa, A. R., Ramjan, L. M., Maneze, D., & George, A. (2021). Conducting population health research during the COVID-19 pandemic: impacts and recommendations. Sustainability, 13(6), 3320.

Virta, E., Sam, D.L. and Westin, C., 2004. Adolescents with Turkish background in Norway and Sweden: A comparative study of their psychological adaptation. Scandinavian journal of psychology, 45(1), pp.15-25.

Vousden, N., & Knight, M. (2024). Ethnicity, disadvantage, and pregnancy outcomes in the UK. Obstetrics, Gynaecology & Reproductive Medicine.

Waldenström, U. (2003). 'Women's memory of childbirth at two months and one year after the birth,' Birth, 30 (4):248-253.

Wang, C.C., & Geale, S.K. (2015). The power of story: Narrative inquiry as a methodology in nursing research. International Journal of Nursing Sciences, 195-198.

Ward, J. M. (2019). Sub-Saharan African Refugee Mother and Health Care Provider Experiences, Perceptions, and Needs.

Ward, M., Kristiansen, M., & Sørensen, K. (2019). Migrant health literacy in the European Union: A systematic literature review. Health Education Journal, 78(1), 81-95.

Warrener, J., & Douglas, V. (2023). Black Lives Matter in higher education: conversations about race to transform the lived experience of Black (African-Caribbean) staff in UK universities. Critical and radical social work, 1-18.

Watson, N. N., & Hunter, C. D. (2016). “I had to be strong” tensions in the strong Black woman schema. *Journal of Black Psychology*, *42*(5), 424-452.

White, R. E., & Cooper, K. (2022). Grounded theory. In Qualitative research in the post-modern era: Critical approaches and selected methodologies (pp. 339-385). Cham: Springer International Publishing.

Wiles, R. (2013). What are Qualitative Research Ethics? London: Bloomsbury Academic.

Wilkinson, C., & Wilkinson, S. (2019). The only way is ethics? Applying for National Health Service ethical approval and governance for research with children. Children's Geographies, 17(4), 480-486.

Wilson, C., Crawford, K., & Adams, K. (2022). Translation to practice of cultural safety education in nursing and midwifery: A realist review. Nurse Education Today, 110, 105265.

Wojnar, D. M. (2015). Perinatal experiences of Somali couples in the United States. Journal of Obstetric, Gynecologic, and Neonatal Nursing : JOGNN, 44(3), 358-369.

Women and Equalities Committee. (2023). Black Maternal Deaths https://publications.parliament.uk/pa/cm5803/cmselect/cmwomeq/1611/report.html

Woodland, L., Blignault, I., O'Callaghan, C., & Harris-Roxas, B. (2021). A framework for preferred practices in conducting culturally competent health research in a multicultural society. Health research policy and systems, 19, 1-11.

World Health Organization. (2015). Global strategy for women's, children's and adolescents' health 2016–2030. Geneva: WHO.

World Health Organization. (2018). Report on the health of refugees and migrants in the WHO European region: no public health without refugee and migrant health.

Yadollahi, S., Ebadi, A., & Asadizaker, M. (2020). Measuring Cultural competence in nursing: a review study. Journal of Client-Centered Nursing Care, 6(3), 203-212.

Yeung, S. (2016). Conceptualizing cultural safety. Journal for Social Thought. 1.

Yin, R. K. (2018). Case study research. Design and methods (6th ed). Thousand Oaks. CA. Sage.

Young, S., & Guo, K. L. (2020). Cultural diversity training: the necessity of cultural competence for health care providers and in nursing practice. The health care manager, 39(2), 100-108.

Zegers, C., & Auron, M. (2022). Addressing the challenges of cross-cultural communication. Medical Clinics, 106(4), 577-588.

Zenebe, K., Alem, H., Merga, A., Abate, G., Taha, H., & Melese, M. J. G. O. (2016). Prevalence of cultural malpractice and associated factors among women attending MCH Clinic at Debretabor governmental health institutions South Gondar, Amhara Region, North West Ethiopia, 2015. Gynecol Obstet (Sunnyvale), 6(371), 2161-0932.

Zhang, X., & Wang, X. (2021). Team learning in interdisciplinary research teams: antecedents and consequences. Journal of knowledge management, 25(6), 1429-1455.

Zhu, B. (2023). What Steps can be Taken to Reduce Unconscious Bias in the Workplace?. Academic Journal of Management and Social Sciences, 5(1), 200-202.

Zikmund, W. G., D'Alessandro, S., Winzar, H., Lowe, B., & Babin, B. (2014). Marketing research. Sydney: Cengage Learning.

Appendix 1: Mind Map

1. Black African	2. Women	3. Pregnant	4. Maternal Health Services	5. Culture	6. Competent
Black African African Afro Caribbean American Ethnic minority Black Ethnic minority BME Blacks Ethnic groups BAME	Women Woman Female Girl Mother	Pregnant Pregnancy Childbirth Maternal Expectant	Maternal health services Antenatal care Antenatal service Maternity service Prenatal care	Culture Cultural Culturally	Competent Competency

Appendix 2: Literature search- Health databases

Database	Time limit	Search terms	Total papers	Notes
CINAHL plus	2000-2024	1 and 2 and 3 and 4 and 5 and 6	288	**Alert created once a month any time span**
MEDLINE	2000-2024	1 and 2 and 3 and 4 and 5 and 6	819	
INTERMID , INTERNURSE and MAH complete	2000-2024	1 and 2 and 3 and 4 and 5 and 6	40	
PUBMED	2000-2024	1 and 2 and 3 and 4 and 5 and 6	86 Custom Filter of cultural competency was applied	**Terms (1-6) generated 2093,049 results**
COCHRANE	2000-2024	1 and 2 and 3 and 4 and 5	92	
SCOPUS	2000-2024	1 and 2 and 3 and 4 and 5	4	
Total			1329	

Appendix 3: Literature search- Grey literature/sociology/social care databases

Database	Time limit	Search terms	Total papers
Open dissertations **British Library**	none	Black African Cultural competency Antenatal care	58
Open Access Theses and Dissertations	none	Black African Cultural competency Antenatal care	13
Open Research Library	none	Black African Cultural competency Antenatal care	0
Open Dissertations	2000-2024	1 and 2 and 3 and 4 and 5 and 6	0
PsycINFO	none	All terms except competency	33
Social Care Online	None	Black African	13

		Pregnancy	
Google Scholar	2000-2024	Cultural competency Black African Pregnancy Antenatal	1141
JSTOR	2000-2024	Black African Pregnancy Cultural competency Antenatal care	45
Total			1303

Appendix 4: Interview schedule

INTERVIEW SCHEDULE IRAS 261070 8/9/2021 V1

Project title

A qualitative study of migrant Nigerian mothers' and midwives' perceptions of cultural competency in antenatal care

The proposed research questions

1. How do the perceptions of migrant Nigerian women differ from midwives' perceptions of cultural competency in routine antenatal care?
2. What are the cultural needs of migrant Nigerian women and how are their needs currently addressed within routine antenatal care provision in the NHS?

Interview schedule designed utilising the Campinha-Bacote (2002) model combined with the Papadopoulos et al. (1998) model for developing cultural competency.

Campinha-Bacote (2002) model of cultural competency in the delivery of healthcare services consists of five dimensions - ASKED FRAMEWORK:

Cultural Awareness-a process in which healthcare professionals consciously acknowledge their own cultural backgrounds, which helps them avoid biases toward other cultures.

Cultural Skills-defined as the ability to obtain the necessary information from patients via culturally-appropriate conduct and physical assessment.

Cultural Knowledge-a process in which healthcare professionals open their minds to understand variations in cultural and ethnic traits as they relate to patient attitudes toward illness and health.

Cultural Encounters-stereotyping is avoided through the interaction between healthcare professionals and members of different cultures. During this process over-reliance on conventional views is discouraged.

Cultural Desire-which is the driving force for becoming educated, skilled, competent, and aware of culture; it also presumes a willingness to have transcultural interactions.

Papadopoulos et al. (1998) model for developing cultural competency consists of four dimensions:

Cultural competency -assessment skills, diagnostic skills, clinical skills, challenging and addressing prejudice and discrimination.

Cultural knowledge - health beliefs and behaviours, social, biological, psychological, and anthropological understanding, similarities, and variations.

Cultural awareness-evaluation of personal values and beliefs, self-awareness, ethnocentricity.

Cultural sensitivity -Empathy, interpersonal/communication skills, trust, respect, acceptance, and appropriateness.

The following interview questions act as a guide for the interviewer and may not be asked using the exact words depending on the participant's understanding. However, questions will maintain the essence of what is being asked in order to collect data relevant to research aims. Further questions may be devised during the course of the interview process, this allows reflexibility for the interviewer to explore any responses made by participants (Turner, 2010).

Interview schedule for Nigerian mothers

Warm up questions

How are you and your baby doing?
Are you enjoying being a mum? If negative response, interviewer will provide contact for Birth Reflection clinic, Birth Trauma Association and liaise with Health Visitor /GP.

Background details

Please could you tell me a bit about yourself?
Ethnicity
Age
Whether living alone or with family/ partner's ethnicity (may be different to woman's)
Occupation
Highest level of education
Date of baby's birth
Mother tongue

Have you given birth to a baby in any other country?
Was this your first baby born in the UK?

Cultural awareness

How did the midwife show that she was aware or unaware of which country you were from during your antenatal appointments?

Prompts

How important would it have been for you to have a discussion about coming/migrating from Nigeria during your antenatal appointments?

Did the midwife ask you anything about your experience of living in the UK during your antenatal appointments? If yes, what did she say?

How important would it have been to you for the midwife to ask you about your experience of living in the UK?

Cultural knowledge

Did the midwife do or say anything that showed you that she knew or did not know about how antenatal care is performed in Nigeria?

Prompts

Did the midwife discuss with you any cultural practices or rituals that she already knew about that were performed by Nigerian women during pregnancy?

How important would it have been for the midwife to discuss with you any cultural practices or beliefs that she knew were practiced by Nigerian women during pregnancy?

Cultural skill

During your antenatal appointments did you feel you were able to build a relationship with the midwife?

During your antenatal care did you experience any challenges in attending for your appointments because of your cultural beliefs or practices? If so were you able to discuss this with the midwife?

Prompts

At any time during your antenatal appointments did you feel able or unable to discuss your health or your baby's health with the midwife? Why?

What things did the midwife do or say that made you feel able or unable to talk about your health or your baby's health during your antenatal appointments?

How important was it to you that the midwife allowed time for you to talk about your health and your baby's health during your antenatal appointments?

How important was it to you that the midwife allowed you to talk about any feelings you may have had about how your pregnancy was progressing during your antenatal appointments?

Cultural encounters

How did the midwife show you during your antenatal appointments that she had previously or not previously looked after other Nigerian pregnant women?

Prompts

How important was it to you that the midwife had experience of looking after other Nigerian women?

Was there anything else that you felt the midwife could do or say to show you that she had provided antenatal care to other Nigerian women?

Cultural desire

Did the midwife ask you about your cultural beliefs and values about pregnancy?

Prompts

How important would it have been to you for the midwife to ask you about your cultural beliefs and values about pregnancy?

Did the midwife discuss with you any cultural differences you had of living in the UK compared to Nigeria, if so what did she say?

How important would it have been for you to have any discussion with the midwife about any cultural practices in the UK and how they may have been different to any cultural practices in Nigeria?

Cultural sensitivity

How did the midwife show she respected your values and beliefs about pregnancy during your antenatal appointments ? Could you provide examples of how this was done by the midwife?

Prompt

How important was it to you that the midwife respected your values or beliefs about pregnancy?

How else could the midwife have shown you that she respected your values and beliefs about pregnancy?

Finally, is there anything else you would like to tell me about your experience of antenatal care?

Thank you very much for taking part in this interview.

Interview schedule for Midwife participants

Warm up questions

When did you qualify as a midwife?
When did you last undertake routine antenatal care?
How often do you undertake routine antenatal care?

Background details

Ethnicity
Trained in UK, if no where?
Have you ever worked abroad, if so where?

Cultural awareness

Do you think it is important to be aware of your own cultural beliefs and values when caring for women from different cultural backgrounds during antenatal booking and provision of antenatal care?

Prompts

How would you identify a woman's cultural background?

How important is it to you ask recently migrated women (<4 years) about their experience of living in the UK?

Do you think it is important to acknowledge your cultural background and how it may differ or be similar to a woman's cultural background during antenatal appointments? Please give a reason for your answer.

Cultural knowledge

What do you know about cultural practices/rituals or preferences that Nigerian women perform during the antenatal period?

Prompts

Do you think it is important to discuss with Nigerian women any cultural practices/rituals or preferences that you already know about that are performed during the antenatal period? Please give a reason for your answer.

What is the importance of discussing with Nigerian women any cultural practices/rituals or preferences related to the antenatal period that you are aware of?

Cultural skill

How would you go about building a rapport with a woman from another culture during antenatal booking/appointments?

Prompts

What things do you do or say during antenatal appointments to facilitate a woman to share information with you about her health or her baby's health? Why is this important?

During antenatal appointments do you ensure that women are able to discuss any concerns about their health or their baby's health?

What things do you say or do to ensure that women are able to talk about any concerns they may have about their pregnancy during antenatal appointments?

If you suspected a women was experiencing challenges with attending for antenatal care due to cultural preferences what steps would you take to understand their preferences?

Cultural encounters

Tell me about your experience in looking after African/Nigerian women during routine antenatal care ?

Prompts

Can you discuss any challenges you have faced when providing routine antenatal care for African/ Nigerian women?

Is there anything that you do or say to show women that you have provided routine antenatal care to other African/Nigerian women?

How important is it to you to have experience of providing routine antenatal care to African/Nigerian women?

Cultural desire

Tell me about what you have done to learn more about migrant women's cultural beliefs and values related to pregnancy when providing routine antenatal care.

Prompts

Are you interested in learning from migrant women about how antenatal care is performed in their country? If so why?

How important is it to you that you talk to women about how antenatal care is performed in their country?

Cultural sensitivity

Could you talk about how you show women that you respect their cultural beliefs and

values?

Prompts

How do you explain to migrant women why antenatal care may be different in the UK compared to other countries?

Could you discuss whether it is important to a woman that you are respectful and accept her cultural beliefs about pregnancy?

Have you undertaken unconscious bias training? What was your experience of this?

Have you undertaken any cultural competency training? What was your experience of this?

Finally, is there anything else you would like to tell me about your experience of providing antenatal care?

Thank you very much for taking part in this interview.

Appendix 5: Participant information sheet mothers

UNIVERSITY OF HERTFORDSHIRE INFORMATION FOR MOTHERS

A qualitative study of migrant Nigerian mothers' and midwives' perceptions of cultural competency in antenatal care

What is the purpose of this study?

My name is Sarah Esegbona-Adeigbe. I am a midwife who works in education. I am doing a PhD and I am interested in talking to Nigerian mothers about any care they received during the antenatal period which was important to their culture. I am hoping that this study will highlight the cultural needs of Nigerian women which can be used to provide suitable antenatal care. This study is sponsored by the University of Hertfordshire, the word '**we**' in this document refers to the sponsor and myself.

Do I have to take part?

It is completely up to you whether you decide to take part in this study. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. Agreeing to join the study does not mean that you have to complete it. This will not affect any health care you currently receive or may receive in the future. If there are any changes to the aims of this study I will inform you and ask for your consent again.

Are there any restrictions that may prevent me from participating?

You will need to be Nigerian and over 18 years of age and you should have migrated into UK within the last five years and delivered a healthy baby within the last year.

How long will my part in the study take?

If you decide to take part in this study, you will be involved in an interview that may take up to two hours.

What will happen to me if I take part?

If you agree to take part, I will ask you to sign a consent form, this may be done face to face or I will email you a consent form to sign. I will arrange a suitable time and place of your choice for you to be interviewed. This interview may take place face to face or may be done by telephone or online. During the interview I will ask questions about your experience of your antenatal care with your last baby. I will record the conversation using an audio recorder. The purpose of the recording is to allow me to collect all the information discussed during the interview, which is important for me to explore later.

How will we use information about you?

We will need to use information from you for this research project. This information will include your name, NHS number and contact details. We will use this information to do the research or to check your records to make sure that the research is being done properly. People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code or number instead.

Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in this study.

Who can I contact if I have any questions ?

If you would like further information or would like to discuss any details personally, please get in touch with me, by phone or by email:

Sarah Esegbona-Adeigbe
email: soesegbona@aol.com
mobile: 07912852687

What are the possible risks of taking part?

During the interview you might be asked questions about certain topics which may be upsetting. You can refuse to answer any questions which you feel uncomfortable with, or you can stop the interview at anytime and this will not affect any care you receive.

What are the possible benefits of taking part?

This study may help midwives and clinical staff gain a better understanding of the cultural needs of Nigerian women during antenatal care. This may provide knowledge that can be used to improve antenatal care provision.

What are your choices about how your information is used?

You can stop being part of the study at anytime, without giving a reason, but we will keep information about you that we already have. We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.

How will my taking part in this study be kept confidential?

In this research study we will use information from you and will only use information that we need for this research study.The recorded interview will be written out by a professional transcriber. Only I and the transcriber will have access to the audio recording. Anything you say when taking part in this study may be used but your real name will not be used. No personal information will be used in any written papers, articles or reports.

All personal information will be stored on the University of Hertfordshire's dedicated and secure research storage service which only I will have access to. The copy of the recorded interview will have all personal information removed and will only be accessed by me.

What will happen to the audio recording?

Once the recorded interview has been written and checked by me to make sure it is correct, the audio recording will be deleted.

What will happen to the data collected within this study?

Confidentiality and privacy will be maintained. Confidentiality will only be broken if you disclose that you intend to harm yourself or others and a relevant person will have to be informed which will include your general practitioner. Also, confidentiality will be broken if there has been harm caused to you or there is risk of potential harm to any other individuals. You will also be given contact details of organisations who offer support to women after childbirth.

Any information relating to you (data recorded during study and data provided by you) will remain confidential and stored securely. Direct quotes from any interviews will only be used if this can be done in such a way that you cannot be identified.

The data collected will be stored electronically on the University of Hertfordshire's secure research storage service for ten years after the end of the study, after which time it will be destroyed under secure conditions; all personal information will be removed before being stored.

Will the data be required for use in further studies?

The information from the interviews will be used in a final report and may be published in midwifery, medical or sociological journals or may be used in a chapter in a book. All information collected about you will be kept confidential. You will not be able to be identified in any ensuing reports or publications.

Where can I find out more about how my information is used?

You can find out more about how we will use your information

- at https://www.hra.nhs.uk/information-about-patients/
- our leaflet available from http://www.hra.nhs.uk/patientdataandresearch
- by asking one of the research team or
- by contacting our data protection officer:

Abigail Tomlinson
Data Protection Officer
Legal & Compliance Services

University of Hertfordshire
Hatfield
AL10 9AB
UK

or via email to dataprotection@herts.ac.uk.

Who has reviewed this study?

This study has been reviewed by Harrow Research and Ethics Committee

If there is any revelation of unlawful activity or any indication of non-medical circumstances that would or has put others at risk, the University may refer the matter to the appropriate authorities.

Although we hope it is not the case, if you have any complaints or concerns about how you have been approached or treated during the course of this study, please write to the University's Secretary and Registrar at the following address:

Secretary and Registrar
University of Hertfordshire
College Lane
Hatfield, Herts, AL10 9AB

Thank you very much for reading this information and giving consideration to taking part in this study.

Appendix 6: Participant information sheet midwives

UNIVERSITY OF HERTFORDSHIRE. INFORMATION FOR MIDWIVES

A qualitative study of migrant Nigerian mothers' and midwives' perceptions of cultural competency in antenatal care

What is the purpose of this study?

My name is Sarah Esegbona-Adeigbe I am a midwife who works in education. I am doing a PhD and I am interested in the talking to midwives about any care that was provided to women during their routine antenatal care which considered their cultural background. I am hoping that this study will highlight the cultural needs of women which can be used to provide suitable antenatal care. This study is sponsored by the University of Hertfordshire, the word '**we**' in this document refers to the sponsor and myself.

Do I have to take part?

It is completely up to you whether you decide to take part in this study. If you do decide to take part you will be given this information sheet to keep and asked to sign a consent form. Agreeing to join the study does not mean that you have to complete it. If there are any changes to the aims of this study I will inform you and ask for your consent again.

What will happen to me if I take part?

If you agree to participate, I will ask you to sign a consent form this may be face to face or you will be sent a consent form to sign by email. I will arrange a suitable time and place for you to be interviewed or be involved in a focus group. The interview or focus group may be done face to face, by telephone or online. During the interview/ focus group I will ask questions related to your experience of providing routine antenatal care to Nigerian women. The focus group will also ask about the routine antenatal care that you have provided to Nigerian women and will be moderated by myself. I will have a

Are there any restrictions that may prevent me from participating?

You must either be currently or have been involved in providing routine antenatal care to women.

How long will my part in this study take?

If you decide to take part in this study, you will be involved in an interview or a focus group that may last up to two hours.

Who else will be asked to participate in this study?

I will be seeking support from midwives working in your Trust to discuss this study with Nigerian mothers who will be asked to complete an expression of interest form after reading a participant information sheet similar to this one about taking part in this study. I will be interviewing Nigerian mothers who are over 18 years of age and have migrated into the UK within the last four years and delivered a healthy baby within the last year. Mothers will not be involved in any focus groups.

responsibility of adequately covering all questions within the allocated time. Also, I will have the responsibility to ensure all participants are able to talk fully and explain their answers.

I will record the conversation from the interviews and focus groups using an audio recorder. The purpose of the recording is to allow me to capture all the information discussed during the interview/ focus group, which is important for me to analyse later.

How will we use information about you?

We will need to use information from you for this research project. This information will include your name, workplace and contact details. We will use this information to do the research or to check your records to make sure that the research is being done properly. People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code or number instead.

Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in this study.

Who can I contact if I have any questions ?

If you would like further information or would like to discuss any details personally, please get in touch with me, by phone or by email:

Sarah Esegbona-Adeigbe
email: soesegbona@aol.com
mobile: 07912852687

What are the possible disadvantages or risks of taking part?

During the interview/ focus group you might be asked questions about certain topics which are sensitive or may be upsetting. You can refuse to answer any questions which you feel uncomfortable with, or you can stop the interview/focus group at any time.

What are the possible benefits of taking part?

There are no known direct benefits to you participating in this study. However, the results of the study may help midwives and clinical staff gain a better understanding of how midwives provide culturally relevant care to women. This can be used to increase women's engagement and satisfaction with antenatal care.

What are your choices about how your information is used?

You can stop being part of the study at anytime, without giving a reason, but we will keep information about you that we already have. We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.

How will my taking part in this study be kept confidential?

In this research study we will use information from you and will only use information that we need for this research study. The recorded interview and focus group discussion will be written out by a professional transcriber. Only I and the transcriber will have access to the audio recording. Quotations from people taking part in this study may be used, but real names will not be used. The

electronic data will have all personal information removed and will only be accessed by me with a secure password on the University of Hertfordshire's secure research storage service.

What will happen to the audio recording?

Once the transcript has been completed and checked by me for accuracy, the audio recording will be deleted.

What will happen to the data collected within this study?

Confidentiality and privacy will be maintained. Confidentiality will be broken if you disclose negligence or bad practice, and your Trust will be informed. Also, confidentiality will be broken if there has been harm caused or there is risk of potential harm to yourself or any other individual.

Any information relating to you (data recorded during study and data provided by you) will remain confidential and stored securely. Direct quotes from the interviews and focus groups will only be used if this can be done in a way that you cannot be identified.

The data collected will be stored electronically on the University of Hertfordshire's secure research storage service for ten years after the end of the study, after which time it will be destroyed under secure conditions; all personal information will be removed before being stored.

Will the data be required for use in further studies?

The data will be used in a final report and may be published in midwifery, medical or sociological journals or in chapters in a book. All personal information collected about you will be kept confidential. You will not be able to be identified in any ensuing reports or publications.

Where can you find out more about how your information is used?

You can find out more about how we will use your information

- at https://www.hra.nhs.uk/information-about-patients/
- our leaflet available from http://www.hra.nhs.uk/patientdataandresearch
- by asking one of the research team or
- by contacting our data protection officer:

Abigail Tomlinson
Data Protection Officer
Legal & Compliance Services

University of Hertfordshire
Hatfield
AL10 9AB
UK

or via email to dataprotection@herts.ac.uk.

Who has reviewed this study?

This study has been reviewed by Harrow Research and Ethics Committee.

If there is any revelation of unlawful activity or any indication of non-medical circumstances that would or has put others at risk, the University may refer the matter to the appropriate authorities.

Although we hope it is not the case, if you have any complaints or concerns about any aspect of the way you have been approached or treated during the course of this study, please write to the University's Secretary and Registrar at the following address:

Secretary and Registrar
University of Hertfordshire
College Lane, Hatfield
Herts, AL10 9AB

Thank you very much for reading this information and giving consideration to taking part in this study.

Appendix 7: Consent mothers

University of Hertfordshire UH

IRAS ID: 261070.

Participant Identification Number for this study

CONSENT FORM- Women participants

Title of Project: **A qualitative study of migrant Nigerian mothers 'and midwives 'perceptions of cultural competency in antenatal care**

Name of Researcher: **Sarah Esegbona-Adeigbe**

	Please initial box	
	YES	NO
1. I confirm that I have read the information sheet dated.....22/10/2023..... (version..4..) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐	☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.	☐	☐
	☐	☐

3. I agree to let the researcher use quotes from my interview, as long as this is done in such a way that I cannot be identified.

4. I understand that relevant sections of my medical notes and data collected during the study, may be looked at by individuals from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records. ☐ ☐

5. I have been told how information relating to me (data obtained in the course of the study, and data provided by me about myself) will be handled: how it will be kept secure, who will have access to it, and how it will or may be used. ☐ ☐

6. I understand that confidentiality and privacy will be maintained and will only be broken if I disclose negligence or bad practice which will be reported to the NHS Trust or if there is risk of harm to myself or others. ☐ ☐

7. I understand that my General Practitioner will be contacted if there is risk of harm or if there has been harm to myself. ☐ ☐

8. I understand that the information collected about me will be used to support other research in the future and may be shared anonymously with other researchers. ☐ ☐

9. I agree to take part in the above study. ☐ ☐

Name of Participant Date

Signature :

Name of Person seeking consent: Signature

When completed: 1 for participant; 1 for researcher site file; 1 to be kept in medical notes. IRAS 261070 22/10/23 V4

Appendix 8: Consent form midwives

IRAS ID: 261070

Participant Identification Number for this study:

CONSENT FORM- Midwife participants

Title of Project: **A qualitative study of migrant Nigerian mothers 'and midwives 'perceptions of cultural**

competency in antenatal care

Name of Researcher: **Sarah Esegbona-Adeigbe**

	Please initial box
	YES
1. I confirm that I have read the information sheet dated.....15/5/2022..... (version..4..) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐ ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.	☐ ☐

3. I agree to let the researcher use quotes from my interview or focus group as long as this is done in such a way that I cannot be identified. ☐ ☐

4. I have been told how information relating to me (data obtained in the course of the study, and data provided by me about myself) will be handled: how it will be kept secure, who will have access to it, and how it will or may be used. ☐ ☐

5. I understand that the information collected about me will be used to support other research in the future and may be shared anonymously with other researchers. ☐ ☐

6. I understand that confidentiality and privacy will be maintained and will only be broken if I disclose negligence or bad practice which will be reported to my Trust. ☐ ☐

7. I have not been involved in the recruitment of mothers to this research Study. ☐ ☐

8. I agree to take part in the above study. ☐ ☐

Name of Participant Date

Signature

Name of Person seeking consent Date

Signature

When completed: 1 for participant; 1 for researcher site file; 1 to be kept in medical notes. IRAS 261070 23/3/2022 V3

Appendix 9: HRA approval

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Dr Laura Abbott
Dept. of Allied Health Professions, Midwifery and Social Work
School of Health and Social Work
University of Hertfordshire College Lane Campus
Hatfield
AL10 9AB

Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

26 May 2022

Dear Dr Abbott

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**A qualitative study of migrant Nigerian mothers' and midwives' perceptions of cultural competency in antenatal care**
IRAS project ID:	**261070**
Protocol number:	**n/a**
REC reference:	**21/PR/1597**
Sponsor	**University of Hertfordshire**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report

(including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The standard conditions document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **261070**. Please quote this on all correspondence.

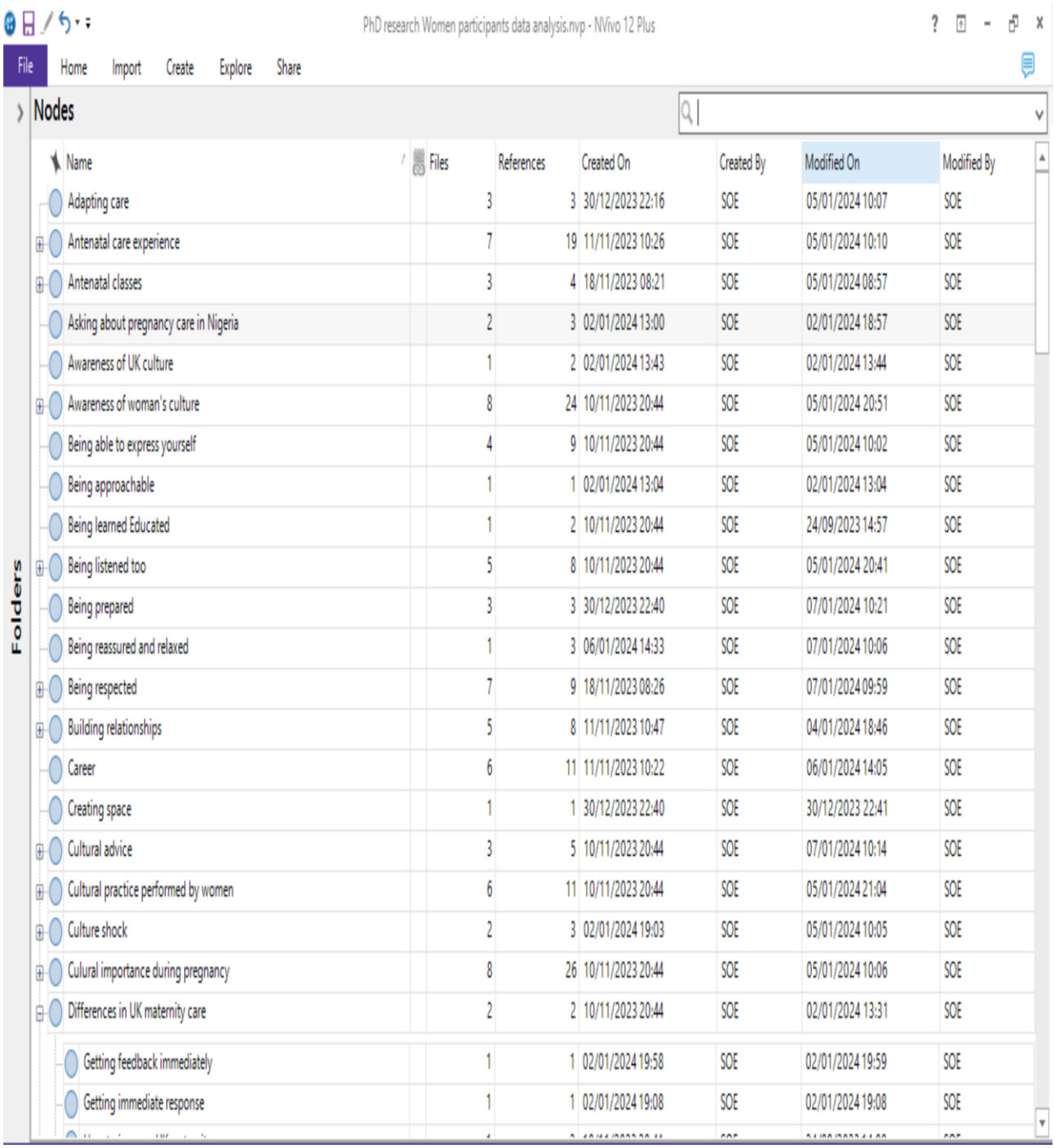
Yours sincerely,
Kelly Rowe

Approvals Manager

Email: approvals@hra.nhs.uk

Copy to: *Ms Ellie Hubbard*

Appendix 10: Initial NVivo codes from transcripts



Name	Files	References	Created On	Created By	Modified On	Modified By
Adapting care	3	3	30/12/2023 22:16	SOE	05/01/2024 10:07	SOE
Antenatal care experience	7	19	11/11/2023 10:26	SOE	05/01/2024 10:10	SOE
Antenatal classes	3	4	18/11/2023 08:21	SOE	05/01/2024 08:57	SOE
Asking about pregnancy care in Nigeria	2	3	02/01/2024 13:00	SOE	02/01/2024 18:57	SOE
Awareness of UK culture	1	2	02/01/2024 13:43	SOE	02/01/2024 13:44	SOE
Awareness of woman's culture	8	24	10/11/2023 20:44	SOE	05/01/2024 20:51	SOE
Being able to express yourself	4	9	10/11/2023 20:44	SOE	05/01/2024 10:02	SOE
Being approachable	1	1	02/01/2024 13:04	SOE	02/01/2024 13:04	SOE
Being learned Educated	1	2	10/11/2023 20:44	SOE	24/09/2023 14:57	SOE
Being listened too	5	8	10/11/2023 20:44	SOE	05/01/2024 20:41	SOE
Being prepared	3	3	30/12/2023 22:40	SOE	07/01/2024 10:21	SOE
Being reassured and relaxed	1	3	06/01/2024 14:33	SOE	07/01/2024 10:06	SOE
Being respected	7	9	18/11/2023 08:26	SOE	07/01/2024 09:59	SOE
Building relationships	5	8	11/11/2023 10:47	SOE	04/01/2024 18:46	SOE
Career	6	11	11/11/2023 10:22	SOE	06/01/2024 14:05	SOE
Creating space	1	1	30/12/2023 22:40	SOE	30/12/2023 22:41	SOE
Cultural advice	3	5	10/11/2023 20:44	SOE	07/01/2024 10:14	SOE
Cultural practice performed by women	6	11	10/11/2023 20:44	SOE	05/01/2024 21:04	SOE
Culture shock	2	3	02/01/2024 19:03	SOE	05/01/2024 10:05	SOE
Culural importance during pregnancy	8	26	10/11/2023 20:44	SOE	05/01/2024 10:06	SOE
Differences in UK maternity care	2	2	10/11/2023 20:44	SOE	02/01/2024 13:31	SOE
Getting feedback immediately	1	1	02/01/2024 19:58	SOE	02/01/2024 19:59	SOE
Getting immediate response	1	1	02/01/2024 19:08	SOE	02/01/2024 19:08	SOE

Appendix 11- Conferences/Seminars

8th May 2024 **Invited talk** Underrepresentation of Black women in research, RCM conference, Liverpool.

5th May 2024 Poster presentation , A qualitative study on Migrant Nigerian mothers and midwives' perceptions of cultural competency in antenatal care, Virtual International Day of the Midwife

2nd May 2024 Poster conference, A qualitative study on Migrant Nigerian mothers and midwives' perceptions of cultural competency in antenatal care, LSBU Doctoral Academy, London South Bank University.

14th February 2024, Poster presentation, A qualitative study on Migrant Nigerian mothers and midwives' perceptions of cultural competency in antenatal care, NHS Research and vision conference, Birmingham

13th July 2023 Decolonisation in School of Nursing and Midwifery, Decolonising Planning Workshop, LSBU

10th November 2022 PhD narrated poster, A qualitative study on Migrant Nigerian mothers and midwives' perceptions of cultural competency in antenatal care MBRRACE launch National Epidemiology Unit, University of Oxford.

14th July 2021 **Invited talk** Antenatal screening for Sickle Cell - Caribbean Nurses and Midwives Association (UK)

5th May 2021 **Invited talk** Cultural safety- Midwifery hour, Maternity and Midwifery Forum

5th May 2021 **Invited talk** Conference presentation- How Midwifery Education Can Reduce Racial Disparities in Maternity- Racial Disparities in Maternity Conference, Midwifery Society, LSBU

15th January 2021 - **Invited talk** Conference presentation- The truth about women's health- past imperfect- Part three- Equality, Food, Water and Politics 13-15th January, London Southbank University

19th November 2020 **Invited talk** Conference presentation- Changes to Midwifery Education Through Covid, Dismantling racism and inequalities in Midwifery Education, Maternity and Midwifery Forum

16th September 2020 Poster presentation -A qualitative study on Migrant Nigerian mothers' and midwives' perceptions of cultural competency in antenatal care, Wales and Southwest England Maternity and Midwifery Festival

10th September 2020- Poster presentation-PhD studies, A qualitative study on Migrant Nigerian mothers and midwives' perceptions of cultural competency in antenatal care, GLOW Women's International Conference

4th May 2020 Poster presentation-PhD studies, Virtual Day of the Midwife, A qualitative study on Migrant Nigerian mothers and midwives' perceptions of cultural competency in antenatal care, International conference

July 2019 Poster presentation A qualitative study on Migrant Nigerian mothers and midwives' perceptions of cultural competency in antenatal care-PhD studies, LSBU Research Conference

Appendix 12: Publications

Esegbona-Adeigbe, S (2023) Underrepresentation of Black women in UK Research, December 2023, MIDIRS, Midwifery digest. 33:4.

Esegbona-Adeigbe, S. (2022). Integrating Cultural safety into midwifery education, Practising Midwife, vol 25, issue 8, September, pages 37-3

Esegbona-Adeigbe, S. (2022). Unconscious bias, should there be a concern about unconsciousness incompetence. Maternity and Midwifery Forum https://www.maternityandmidwifery.co.uk/tag/sarah-esegbona-adeigbe/

Esegbona-Adeigbe, S. (2021). A cultural lens on shared decision making, December 2021- MIDIRS Midwifery digest

Esegbona-Adeigbe, S. (2021). The impact of a Eurocentric curriculum on racial disparities in maternal health. *European Journal of Midwifery*, *5*.

Esegbona-Adeigbe, S. (2020). Cultural safety in midwifery practice- protecting the cultural identity of the woman, Practising Midwife, vol 33, issue 11, December.

Esegbona-Adeigbe, S. (2020). COVID-19 and the risk to Black, Asian and minority ethnic women during pregnancy. *British Journal of Midwifery*, *28*(10), 718-723.

Esegbona-Adeigbe, S., & Olayiwola, W. (2020). The importance of men in the eradication of FGM June 2020, MIDIRS Midwifery Digest

Esegbona-Adeigbe, S., & Olayiwola, W. (2020). Reducing the incidence of stillbirth in Black women. *British Journal of Midwifery*, *28*(5), 297-305.

Esegbona-Adeigbe, S (2020) Quality versus quantity in online teaching during the Covid 19 pandemic, Maternity and Midwifery Forum, https://www.maternityandmidwifery.co.uk/quality-versus-quantity-in-online-teaching-during-the-covid-19-pandemic/

Esegbona-Adeigbe, S. (2020). Impact of COVID-19 on antenatal care provision. *European Journal of Midwifery*, *4*.

Esegbona-Adeigbe, S. (2018). Cultural qualities and antenatal care for Black African women: A literature review. *British Journal of Midwifery*, *26*(8), 532-539.

Esegbona-Adeigbe, S. (2013). Care of the woman with sickle cell disease in pregnancy. *British Journal of Midwifery*, *21*(7), 464-471

Books

Esegbona-Adeigbe, S, 2022 - Transcultural care in midwifery practice- Concepts, care and challenges, Elsevier publishing company

Appendix 13: Theme 9: Experiences in labour

Theme	Categories
9. **Experiences in labour**	**'*Getting yourself prepared'* Preparation for labour**
	It was a good experience
	***'They really did a good job'* Midwives care in labour**